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**An Investigation into the Effectiveness of a
Manualised Group Treatment Programme for Chronic Health
Conditions**

A thesis presented in partial fulfillment of the requirements for the degree of

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in

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ABSTRACT

Chronic health conditions (CHC) such as cardiovascular disease, diabetes, asthma and chronic obstructive pulmonary disease can have a significant psychological impact. Group interventions designed to treat a heterogeneous range of chronic health conditions that are implemented in a naturalistic clinical setting are scarce. Two manualised group interventions were developed based on a biopsychosocial model framework. The pilot manual was amended from participant and staff feedback, and changes were incorporated into the main well-being manual. The present study aimed to explore the effectiveness of the Manualised Group Treatment Programme. A mixed methods approach was used to investigate whether the Manualised Group Treatment Programme was effective in improving quality of life and reducing distress in clients with a chronic health condition. Participant and clinician experiences of the therapeutic groups were studied. Participants' quality of life and distress as measured by the Hospital Anxiety and Depression Scale, Outcome Rating Scale and Short Form-12 remained stable. A thematic analysis was conducted following semi structured interviews with six clients who attended either the pilot group or main well-being group and the three clinicians who facilitated the programme. The results identified that participants benefited from realising they were not alone with having a CHC and could relate to others who faced difficulties managing their CHC. Participants implemented skills they learned in the group and improved their communication with their health care professionals. However, they were apprehensive about attending the groups and how they would be perceived by others. Participants used downward social comparisons as a way of feeling better. They perceived other group members to be worse off than them. The clinicians' beliefs about therapeutic groups' effectiveness changed from considering one-on-one treatment as the only optimum method for therapy delivery.

Their core belief remained focused on meeting client needs. Feedback from the clinicians regarding the effectiveness of the manualised programme was positive. They evaluated the programme as fit for its intended use. This study highlights some of the difficulties in implementing evidence based efficacious therapy as it is applied and practiced in a naturalistic clinical setting. The study's limitations included the low number of participants, as well as the fact that several participants had previous ongoing individual therapy. This affected group processes and how participants regarded each other and their illness. This study has added to the limited health or psychological treatment group literature within New Zealand as well as contributing to the international knowledge base on group centred treatments for chronic health conditions.

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No man is an island, entire of itself; every man is a piece of the continent, a part of the main. —John Donne (1572–1631), *Devotions Upon Emergent Occasions, Meditation XVII*. My thesis journey had input from many, and failure to name you all is not the same as failing to remember how it would have been impossible to complete this journey alone. This is my attempt to name some of the kind souls to whom I owe an unforgettable amount of gratitude.

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CHAPTER 1

This chapter begins by defining chronic health conditions and looking at their current prevalence globally, in New Zealand, and in the Mid-Central health region. Next, a rationale for undertaking this study and an overview of the thesis is provided. The study investigated the effectiveness of a manualised group treatment programme, and whether participation improved the participants' quality of life and reduced their distress levels. It also explored the experiences of both group participants and the clinicians who facilitated the groups.

1.1 Background

The terms chronic health condition (CHC), chronic disease and chronic illnesses, are used interchangeably in health literature and data collection. This makes a concise definition problematic (Erdem, Prada, & Haffer, 2013). Thus, the term CHC is often given the same definition as chronic illness or chronic disease. Nevertheless, a popular definition is that a CHC is an ongoing condition or illness that lasts a year or more, requires ongoing medical attention and limits daily living activities. This is a very broad definition and can encompass physical and mental illnesses, behavioural conditions such as substance and addiction disorders, cognitive and neurological impairment and developmental disabilities (Koch, Rumrill, Conyers, & Wohlford, 2013).

Consensus within the literature is that CHCs are often complex, and have a marked impact on the psychological well-being and functioning of individuals and their social networks (Dobbie & Mellor, 2008; Perrin, Bloom, & Gortmaker, 2007). CHCs vary markedly in complexity, onset, illness outcome, degree of disability, and rates of decline. They require sophisticated care. An individual may have to contend with the

impact of an illness when they receive a diagnosis, and also at varying points later in their lives (Larsen, 2009). Often the treatment goal is not curing a CHC, but preventing increased levels of disability, or maintaining and improving future years of healthy life and function. In reality, most individuals are unlikely to return to health levels experienced before a CHC onset (Shih & Simon, 2008).

For Massey University's Psychology Health Conditions Service, the term CHC indicates the client must have a medically diagnosed chronic physical illness such as diabetes, asthma, chronic obstructive pulmonary disease (COPD) or cardiovascular disease, as one of the referral criteria in order to access its services.

1.2. Global Prevalence

The World Health Organisation (WHO, 2010) classifies CHCs as non-communicable diseases or diseases which are not transferable or infectious. They list four main types of non-communicable disease including cardiovascular disease, cancer, chronic respiratory disease and diabetes. An increasing population, longer life spans and improved treatment of infectious disease, are some of the factors credited with causing a growth in the number of people facing a CHC. The literature also recognises the important trend of the rise in the number of individuals with multiple CHCs (Aspin et al., 2010).

According to the WHO (2010), CHCs are the leading cause of death in both developing and developed countries. In 2008, 36 million deaths globally were attributed to a CHC. Nearly 80% of these deaths occurred in low and middle income countries. Unhealthy diet, high blood pressure, obesity, insufficient exercise and problematic alcohol and tobacco use, were identified as major contributors to this. Also, in these

countries 29% of CHC deaths occurred in people younger than 60 years old, compared to 13% in higher income countries. In 2010 WHO projected a significant increase globally in CHCs over the next decade, rising by at least 15% to 40 million deaths by the year 2020. Similarly, Mathers and Loncar (2006) predict that global deaths due to CHC are expected to reach 66% by the year 2030. Importantly, one of the highest regions to be impacted is the Western Pacific region, which includes New Zealand, with an estimated 12.3 million deaths by 2020.

Whilst the number of people with CHCs is increasing, it is estimated that up to 50% of people with a CHC remain either undiagnosed or untreated (Connolly, Kenealy, Moffit, Sheriden, & Kolbe, 2010). Globally, world health systems are faced with the increasing problem of people requiring physical and psychological interventions for CHCs. This is highlighted by White (2001) who estimates that between 20 to 25% of individuals with a CHC experience psychological difficulties.

Numerous studies recommend that psychological services which provide effective and timely psychological assistance for CHC management need to be developed, to address the escalating problem and burden of treatment (Belar, 1997; Connolly et al., 2010; Epping-Jordan, Pruitt, Bengoa & Wagner, 2004). Specifically, Epping et al. (2004) state effective strategies which transcend individualised treatments need to be developed.

1.3 Chronic Health Conditions in New Zealand

The New Zealand Ministry of Health (MoH) (2010) mortality statistics, indicate that approximately 14,000 of 28,601 deaths in the year 2007 were due to chronic illnesses. Nearly 29% of all deaths were attributable to ischemic heart disease (19.7%)

and cerebrovascular disease (9.2%) alone. Chronic obstructive pulmonary disease accounted for 1,647 deaths, renal failure for 288, and diabetes mellitus was responsible for 847 recorded mortalities. Furthermore, in 2006 132 individuals died from asthma (MoH, 2010).

In New Zealand, it is estimated that at least 51% of adults with a chronic illness have two or more CHCs (Aspin et al., 2010). They report that in New Zealand, the management of chronic illness is guided primarily by the New Zealand Health Strategy, the Primary Healthcare Strategy, and He Korowai Oranga (the Māori Health Strategy). Further, they comment that individuals with multiple CHCs face challenges accessing and coordinating timely services. Nationally and globally, the increased burden that CHCs place on health systems is widely recognised. Notably, current health policy is not adequate to meet the future demand for complex care, as the predominant focus is on individual CHCs (Aspin et al., 2010).

One of the biggest challenges in New Zealand is the disparity which exists between Māori and non-Māori. In 2006, Māori life expectancy for both genders from birth was at least eight years less than that for non-Māori (MoH, 2010). Chronic illnesses such as ischemic heart disease, diabetes, COPD and cerebrovascular disease are the leading causes of death among Māori. Further, cardiovascular disease mortality for Māori is two-and-a-half times higher than for non-Māori, while stroke mortality is over one-and-a-half times higher for Māori than for non-Māori (MoH, 2010).

Little research has been conducted into the psychological impact and treatment of CHCs. Certainly; group therapies to treat the psychological impact of CHCs remain underutilised in New Zealand.

1.4 The Health Conditions Psychology Service

An initiative between Mid-Central District Health Board and Massey University for psychological interventions for people with a range of CHCs, was established at Massey University's Psychology Clinic (Palmerston North) towards the end of 2007. The Health Conditions Psychology Service (HCPS) is a free service providing psychological therapy to those with chronic illness and their family members. According to Ross, Malthus, Berrett and Harvey (2009), the aims and objectives of the service are to improve clients' motivation, enrich quality of life (by enhancing emotional functioning and self-management of the CHC), promote participation in activities, improve communication and social support, and reduce distress such as anxiety and depression. Other organisations exist locally which complement the HCPS and provide health services for pain, mental health and physical activation as well as specific CHC care such as diabetes services. However, currently, there is an increasing demand on HCPS services to treat psychological difficulties arising from a CHC. The focus of therapy to date, has been with evidence-based individual services to clients using therapy based on international research and guidelines.

In general, local rising demand outstrips available resources, thus potentially prolonging suffering experienced by clients. Solutions to provide services to a heterogeneous group of clients with an equally heterogeneous range of problems related to their CHC were required. At the same time, it was important to maintain robust, proven and effective treatment based on research. Hence, a manualised programme for implementation in a therapeutic group for CHCs was developed. The present research examines the effectiveness of the therapeutic groups provided by the Service and

investigates whether the groups achieved the aim of improving quality of life and reducing levels of distress for those affected by a CHC. The results of this study have important ramifications in adding to the body of knowledge for improving services for people with a CHC both in New Zealand and internationally.

1.5 Study Rationale

Research supports the fact that receiving group psychotherapy produces better outcomes than either not receiving psychotherapy or being put on a wait list (Lambert & Ogles, 2004). Therefore, a growing number of group interventions for people with serious medical and health conditions, have sought to provide strategies and skills, to help affected people manage the psychological distress associated with chronic illness (Bower, Kemeny, & Fawzy, 2002; Lambert & Ogles, 2004; Lorig et al., 2006). Additionally, research supports the fact that treatment groups for CHCs provide unique opportunities which are advantageous. Aside from providing information simultaneously to a number of individuals, CHC groups reduce isolation and provide social support. Furthermore, CHC groups provide opportunities for modelling different strategies, and for members to gain wider feedback through the discussion of ideas and experiences (Bower et al., 2002). Studies indicate manualised group treatment can improve quality of life and alleviate psychological distress (Burlingame & Beecher, 2008; Burlingame, MacKenzie, & Strauss, 2004) and derived from evidence based approaches, have been shown to be as efficacious as individual therapy (Wade, Treat, & Stuart, 1998).

Despite evidence supporting psychological group therapy in chronic health care, some debate still exists. In comparison to individualised treatment, there is a dearth of

research on group therapies and how these are implemented and evaluated. Research which considers various modalities of therapy, and research which considers groups with mixed or diverse types of CHC is especially lacking. This is supported by studies such as Barakat, Gonzales and Weinberger (2007), who report that group interventions for chronic health care research remain underdeveloped. Research conducted to date often lacks clear descriptions of the group intervention, while evaluation of its effectiveness remains limited. Further, their stated theoretical approaches remain poorly defined and there is a lack of empirical evidence to support treatment effectiveness (Barakat et al., 2007). In addition, CHC groups developed using cognitive behaviour therapy (CBT) as a modality, remain one of the few researched psychological therapies. The primary objective of this type of therapy is frequently symptom reduction, psychosocial adaptation and increased self-management (Barakat et al., 2007).

A manualised group treatment programme was developed for the HCPS, to be implemented and evaluated in a therapeutic group for a heterogeneous population with equally heterogeneous CHCs. Payne and Payne (2004) suggest programme evaluation is not a specific method, outcome measure or technique but rather is used as a mechanism to support or introduce change. While traditionally, outcome measures are used to provide accountability for resources, evaluation can also consider success in other terms such as the value of social perspectives or social action. The programme developed for the HCPS was based on researched and proven group and individual treatments for CHCs conducted both internationally and in New Zealand. The overall purpose of the present study was to develop and evaluate the manualised group

treatment programme to deal with the psychological consequences of having an ongoing CHC.

Existing evidence indicates that group programmes are effective for a number of distinct health conditions such as cardiac rehabilitation (Queensland Health, 2004), asthma (Ringsberg, Lepp, & Finnstrom, 2002), diabetes (Fisher, Thorpe, DeVellis, & DeVellis, 2007) and COPD (Kunik et al., 2008). However, limited research covers group therapy for a range of multiple chronic conditions such as Spurgeon, Hicks, Barwell, Walton and Spurgeon (2005), for diabetes, asthma, and hypertension, and Lorig et al. (1999) for heart, lung disease, stroke and arthritis.

The present study aimed to contribute towards better understanding of a group based psychological therapy for CHCs, as it functioned in a naturalistic clinical setting. It also aimed to advance the area of knowledge crucial to treating a diverse population affected by a range of CHC diagnoses.

1.5.1 Study aims.

The initial aim of this study was to evaluate the effectiveness of a manualised group treatment programme for clients with a CHC, and to aid the HCPS in its decision making process. A number of treatment factors could have been studied for this project. In consultation with the HCPS, it was decided to evaluate the manualised group treatment programme in a targeted manner using psychometric inventories currently employed in the Service, and based on likely presenting issues relevant to individuals with a CHC. Therefore, the psychometric results specifically were to ascertain whether the participants' quality of life improved and whether their distress levels reduced. Because an extensive range of presenting issues could exist, it was also decided to

widen the evaluative process from an overtly outcome basis only, and to also consider other concepts such as the strengths and weaknesses of the programme, how it worked and whether there was any resultant behavioural change or action (Payne & Payne, 2004). Thus, the current study also explored the participants' and clinicians' experiences of being part of the manualised group treatment programme. It examined whether other therapeutic factors were present for the participants, whether attending the groups helped them manage the consequences of their CHC and how it impacted on the participants' lives. Given the manualised group treatment programme was being developed for Service use, it was also important to gain the clinicians' viewpoint of using the manuals and facilitating and implementing the groups. In addition, it was important to understand how the participants' and clinicians' experiences may have or may not have been linked or related to the research questions which were:

Was the Manualised Group Treatment Programme effective in improving quality of life and reducing distress in clients with a chronic health condition? What were the participants and clinicians experiences of the groups?

1.6 Thesis Overview

This thesis consists of 12 chapters. Chapter 1 outlines global and national CHC prevalence and provides a rationale for the current study. Chapter 2-Chapter 6 consists of a literature review and overview of the biopsychosocial model, social support, therapeutic groups, quality of life, psychological distress (and the impact of these factors on cardiovascular disease, diabetes, asthma and COPD). Chapter 7 discusses the development and content of the manuals. The study methodology is outlined in Chapter 8, with both quantitative and qualitative findings and results in Chapter 9-Chapter 11.

The conclusions, discussion, recommendations and suggestions for further research are contained in Chapter 12.

1.7 Summary

CHC treatment can be complex, especially for individuals with multiple CHCs. The medical model emphasises acute care for CHC management. Health psychology on the other hand, seeks to develop a person-centred approach. This approach encourages the development of programmes which target effective quality participation by individuals in self-care CHC management. This includes programmes that feature behavioural activation, education, care co-ordination and self-monitoring (Stanhope & Henwood, 2014). One such programme is the intervention manuals developed for the HCPS for clients with a CHC. This study explores the effectiveness of the pilot manual and the main well-being group manuals which form the manualised group treatment programme.

Literature Review

CHAPTER 2 THE BIOPSYCHOSOCIAL MODEL

This chapter reviews the literature concerning the biopsychological model. In its clinical practice the HCPS has used the biopsychosocial model to underpin its services. It also uses the model to communicate the way psychological services can impact and improve outcomes to other health professionals and service referrers. When consulting with the HCPS on the development of the manualised group treatment programme, several possible theoretical models of change used in health psychology were considered. These include cognitive behavioural therapy, acceptance and commitment therapy, self-efficacy and motivational interviewing. However, the HCPS Service preferred an eclectic approach, as no one particular approach is suitable for use with all clients. The biopsychosocial model was selected and developed as a framework for linking therapy in the manual in a coherent manner, rather than as a specific model to bring about psychological change. The biopsychosocial model is discussed and critiqued within its current broad context in health research. Both quantitative and qualitative studies are reviewed.

2.1 Definition of the Biopsychosocial Model

Fundamental to health psychology is Engel's (1977) biopsychosocial model. The biopsychosocial model recognises that a reciprocal or mutually affecting relationship exists between biological, psychological and social factors. The ways these factors inter-relate influence both health and illness. Engel's seminal paper challenged the field of psychiatry to not embrace the biomedical approach predominant at that time.

He advocated research based on a systems and hierarchical organisational approach. To rethink current arguments at that time calling for medicine to concentrate research on the organic elements of disease (Engel, 1977). The impact of the biopsychosocial model in the health field has been unique. It provides a pivotal platform enabling an interactive, multiple systems approach to health research and healthcare. It has been used widely to study a number of factors including physical conditions, such as, musculoskeletal disorders (Laisn, Lecomte, & Corbière, 2012), lower back pain (Froud et al., 2014), psychological concepts, such as, predictors of depression in people with Parkinson's disease (Moore & Seeney, 2007) and social concepts, such as, psychosocial adaptation in end stage renal failure (Chan et al., 2014).

Common in the biopsychosocial literature, is the view that the biopsychosocial model provides a perspective which allows for the understanding of the person, and the relationships that influence both health and illness in people's lives (Adler, 2009; Garcia-Toro & Aguirre, 2007; Sperry, 2008).

However, debate exists. On the one hand, the biopsychosocial model has been criticised as lacking in methodological rigour and validation. Thus, the model is seen as having an explanatory rather than an evidential basis (Cohen, Janicki-Deverts, & Miller, 2007). In addition, quantitative studies from a medical perspective recognise that a biomedical approach is often too simplistic when considering the pathology, biochemistry and physiology of a disease. However, biomedical research often fails to account for personal subjectivity and social dimensions which also impact on illness and disability. Moreover, despite similar disease pathology, the biopsychosocial model assumes that outcome variability is caused by psychological or social variables. Thus, a

benefit of this assumption is that the biopsychosocial model is often used as a basis for multifactorial research in medical research. For example, in their quality of life study of women undergoing liver transplants, Lasker, Sogolow, Short and Sass (2011) use biomedical variables (for example, medication effects and fatigue) along with a biopsychosocial model to organise factors identified in the literature into demographic, biomedical, psychological, and sociological categories. In their multivariate study, depression and fatigue were identified as having the most salient effect on participants' quality of life. Yet a limiting factor they identify was the fact that several of the psychosocial measures used had not been established as valid and reliable measures. Thus, it is possible other factors could have impacted on their results (Lasker et al., 2011) and raises questions concerning how the measures they use actually link directly to the biopsychosocial model.

To counter criticisms that the biopsychosocial model is lacking substantial evidence, Adler (2009) comments the biopsychosocial model has a body of evidential support and has relevance for current research. Given the evidence for the model, calls have been made for it to be integrated more widely within practice. Suls, Krantz, and Williams (2013) state that researchers need to use social and psychosocial mediators and moderators more frequently. Furthermore, Suls et al. (2013), and Adler (2009), report that the biopsychosocial model is seldom taught to undergraduate and postgraduate students. Nonetheless, Alonso (2004) argues that holistic concepts of health such as the biopsychosocial model do, in fact now appear in academic contexts. He suggests however, that the change has not been reflected in practical areas of clinical work. Nevertheless, the biopsychosocial model's place in health research continues to

exist as an adjunct to the biomedical model. Moreover, for its status to change there appears to be a need for a well-planned strategic and systematic approach, incorporating the use of the biopsychosocial model into primary health care in a way that health professionals can use in their health practice.

In their thematic analysis of Dutch primary care providers, van Dijk-de Vries et al. (2012), asked participants for their perception of the current use of the biopsychosocial model in CHC management. While the biopsychosocial model was considered essential to CHC care, there was an inherent lack of well-planned strategies such as guidelines, protocols, tools and training within the healthcare system which allowed the use of this approach. However, the sampling of the respondents in this study was biased. The researchers identified participants known to them, whom they considered were experts or knowledgeable about the topic. No mention was given to the criteria of what an expert was, or how knowledgeable was defined. Of the 30 participants approached to take part in the study, none refused participation. The researchers validated their results by inviting 63 participants (including original respondents) in health provision to an invitational conference to discuss the results. Of the 34 participants who attended, one third or 13 members were the respondents.

2.1.1 The biopsychosocial model as a framework.

As discussed, the biopsychosocial model has been criticised as being an explanatory rather than an evidential model. Its wide acceptance and continued use is possibly because it is regarded as a useful mechanism for bridging the gap between the biomedical and psychosocial sciences. Armstrong (1987) proposes that rather than replacing a biomedical approach, the biopsychosocial model should take an integrative

and multidimensional theoretical stance and seek to incorporate its perspective into the biomedical model. Herman (2005) discusses the practical utilisation of both methods in a clinical setting. He suggests a transition is required between the two models to develop realistic methods for its use, and to quantify qualitative concepts in clinical practice.

Further, Frankel and Quill (2005) state for an integrative approach, the biopsychosocial model is a useful framework. They outline ways in which it has been assimilated into clinical practice, research and education. Smith, Fortin, Dwamena and Frankel (2013) have developed a repeatable client centred interview method that identifies individualised relevant biological, psychological and social information from patients' visits. The concept that the biopsychosocial model can be used as a framework is also discussed by MacDonald and Mikes-Liu (2009). They use the model as a framework for their clinical formulation process, to provide a means to assess and develop a working hypothesis in their family clinical work. Importantly, they consider that using this approach allows them to integrate components from other theoretical paradigms into their treatment.

Further, in the current research project the biopsychosocial model is used as a framework as it provides an enhanced understanding of disease and health processes in relationships between health professionals and patients (Alonso, 2004). Thus, it is used to explain therapeutic concepts to the therapeutic group participants, and to integrate and provide a coherent link for the manuals' therapeutic components.

2.2 Summary

This chapter explored the biopsychosocial model and its context and application within health research. While Engel's (1977) model itself has been criticised as being too general and lacking robust evidential support, it has been accepted as having relevant and useful applications within health care research. Currently, the biopsychosocial model is used by some health professionals from diverse clinical orientations, in an attempt to provide a bridge between different approaches inherent in the health field. Still, effort is required in developing practical applications of the model in both research and clinical practice. Nonetheless, it was chosen as a framework for the manuals used in this study, for several reasons. Firstly, the HCPS uses the model to underpin its psychological services. The model is used by the Service to communicate psychological treatment to a wider biomedical referral service environment. Next the model is a useful therapeutic tool to explain to clients how psychological interventions and therapy can help their situation. Lastly, by using the model as a framework for the manuals, it provides a valuable link between health and psychosocial theoretical concepts and therapeutic interventions.

CHAPTER 3 SOCIAL SUPPORT

As mentioned in the previous chapter, the biopsychosocial model proposes biological, physical and social factors influence health and illness. Among the biopsychosocial model concepts social constructs, such as social support, play an important role with health outcomes. But the type and function of social support in groups is also a significant factor in group research, as social support is associated with positive outcomes for group participants (Burlingame, Fuhrman, & Johnson, 2001; Yalom, & Leszcz, 2005). Consequently, this chapter covers social support, given that the concept overlaps both the biopsychosocial model and groups. It reviews the literature concerning social support and how it impacts on a CHC. Interventions designed to improve social support for people with a CHC are also discussed.

3.1 Definition of Social Support

Social support has been heterogeneously applied in research thus making a conclusive definition difficult. Social support research recognises that ties exist within relationships between individuals and their social environment. Often social support includes a wide range of concepts such as social networks and social integration (Berkman, Glass, Brissette, & Seeman, 2000), emotional support (empathy and trust), tangible or instrumental help, appraisal (feedback and self-evaluation) and information sharing (House, Landis, & Umberson, 1988). Social support can also arise from a number of sources such as family, friends, neighbours and professionals (Cohen & Wills, 1985; Helgeson & Cohen, 1996).

3.2 Social Support and Chronic Health Conditions

In terms of this study, having a CHC is considered as potentially causing major stressors in a person's life, which impacts on their ability to be adaptive and to take constructive action to meet their needs. Importantly, social support has a significant impact on a CHC as it can positively or negatively affect physical and psychological well-being (Berkman et al., 2000; Eisenberger, 2013).

Social support was discussed by the clinicians during the development of the manuals, and was considered a key element requiring a therapeutic intervention. In the clinicians experience, individuals in the HCPS were often socially isolated, had fewer social activities and higher incidences of relationship difficulties. These issues are reported in literature reviews for diabetes (van Dam, van der Horst, Knoop, Ryckman, Crebolder, & van den Borne, 2005), heart disease (Graven, & Grant, 2014), COPD (Rabinowitz & Florian, 1992), and asthma (Gallant, 2003).

3.2.1 Positive factors affecting chronic health conditions.

Sluzki (2010) states that a body of research shows that the social environment of a person is not only relevant to disease progression, but also to how well a person copes with a CHC progression. Key beneficial factors identified generally focus on supportive interaction and levels of reciprocity. "Good enough" social support enhances emotional resilience, reduces levels of illness, improves auto-immune system functioning, increases use of health services at appropriate times, and improves illness recovery levels. Psychological factors include an improved sense of self-worth, and emotional support (Sluzki, 2010).

Social support also affects health-related behaviours such as medical adherence levels (DiMatteo, 2004; Johnson, Jacobson, Gazmararian, & Blake, 2010), can act as a buffer, offer instrumental support or mitigate negative appraisals (Cohen & Wills, 1985; Lewis et al., 2001). Furthermore, perceived social support has a positive influence on psychological adjustment, and health outcomes, especially in cardiovascular disease (Penninx, Kriegsman, van Eijk, Boeke, & Deeg, 1996).

3.2.2 Negative factors affecting chronic health conditions.

Cohen and Wills (1985) propose that a CHC can lead to a deterioration of perceived social support and social support networks, which has a reciprocal detrimental effect on health. A lack of social support leads to increased feelings of loneliness and isolation and declining levels of well-being. This can be compounded when an individual is dependent on quality social support for their care (Schreurs & de Ridder, 1997).

Holahana, Holahana, Moosb, and Brennanb (1997), suggest avoidant forms of coping, such as denial of the effects of an illness, are in the longer-term typically harmful to disease adjustment. Further, Sluzki (2010) suggests negative social support can distract and enable treatment avoidance to occur when health problems develop. Furthermore, Cohen (2004) reports individuals with poorer recovery from disease and higher mortality rates had poor social support.

3.2.3 Mediating factors affecting social support.

Sluzki (2010) suggests that identifying social support and the quality of an individual's social network can be predictive in identifying clients who are more prone

to health impacts, such as depression. Further, the degree a person is able to access social support is dependent on their coping styles, and the availability and quality of social support (Heaney & Israel, 2008). DiMatteo (2004) found that family cohesiveness was important, and individuals who perceive themselves to be from a close nurturing family were more likely to be adherent medically. Another mediating factor consists of the personal qualities of people within the support network (Finfgeld-Connett, 2005).

3.3. Social Support and Groups

Research has focused predominately on social support and social networks as it applies to an individual, and evidence supports its benefit in health outcomes (Eisenberger, 2013). However, social support also exists within a group context as it occurs within a therapeutic group. Reed, Harrington, Duggan, and Wood (2010) report that a group setting is perceived as being a nurturing environment, where individuals are able to achieve individual therapeutic outcomes, and learn from each other. They suggest groups enable participants to re-establish a positive social view. Mallinckrodt (1989) proposes that an outcome of gaining social support from within a group, enables participants to improve social support outside of the group.

3.3.1 Social comparison within groups.

Self-monitoring and self-perception are considered important aspects of social skills and can impact on social support received within a group setting. Often, studied more from an individual rather than a therapeutic group perspective, social comparison concepts are comprised of the perception of another person, perception of self in

relation to others, and how a person perceives others' perception of themselves (Furnham & Capon 1983).

Festinger (1954) proposes the social comparison theory. He suggests individuals seek to maintain a sense of normalcy, and desire to be positively different from others through the process of comparison. In times of uncertainty, such as when an individual experiences high anxiety, people increase affiliative behaviours and endeavour to seek others to find ways about how they should feel or think. Davison, Pennebaker, and Dickerson (2000) suggest that social comparison is intrinsic in health care settings.

Within group research, Turner (1991) reports individuals are influenced by the norms of the group. Paquin, Kivlighan, and Drogosz (2013) propose social comparison influences individuals' outcomes when they compare themselves to other group members. Further, social comparisons within self-help groups, according to Dibb and Yardley (2006), can either be positive or negative in direction. An individual can view themselves as being better off or worse than others. If group members experience high levels of symptom change, then individuals making less change, were likely to negatively compare themselves and report less symptom change. Paquin et al. (2013), surmise that social comparison could be a negating factor in group outcomes. The result is decreased therapeutic outcome for individuals.

3.4 Social Support Interventions

Hogan, Linden, and Najarian (2002) report that research on interventions targeting skills training, relationship building and reciprocal social support, show overall beneficial outcomes. Also, psycho-education on topics related to social support, has relevant clinical utility especially if social support is enhanced. Sluzki (2010)

suggests that personal network enhancement training targeting increasing levels of emotional support, practical support, and accepting feedback from others, would promote health enhancing behaviours.

Given the relevance of social support in the literature, and the prevalence of social isolation within the HCPS client population, it is essential that the manuals address the issue of social support. Heaney and Israel (2008) propose social support interventions focus on four areas: enhance existing social support, develop new social support, enhance social support through the use of local helpers, and enhance community level social support. Cohen (2004) suggests that the improvement of existing social support networks is beneficial for individuals with a CHC.

Thus, the aim of the manuals is to engage participants and improve social support within two areas. The first is to identify current social support and assess the quality of that support. This would enable individuals to potentially counter the adverse effects of stress, and increase the perceived availability of interpersonal resources. The second area is to improve social support and communication with health professionals. Integrating the clinical goals proposed by health professionals with a person's real life environment can be problematic. For many clients, gaining the right or accurate information from providers to be able to make wise and informed decisions for their lives is vital. Achieving clear communication and interactions with health professionals is essential but seldom realised (Marks, Allegrante, & Lorig, 2005). Thus, it is important that a person is not overwhelmed as they seek to identify key needs and ask questions which may help them. Achieving clear and open communication with health

care providers is crucial in helping an individual understand, manage and subsequently, adhere to their medical regimen (Diamond & Scheifler, 2007).

3.5 Summary

This chapter explored social support and the impact it has on CHC progression and the ability of a person to adapt to a CHC. Social support within groups was reviewed, including the influence social comparison can have within a therapeutic group setting. Group interventions designed to improve social support were also discussed.

Improving participants' social support was considered a crucial aspect in the development of the manualised group treatment programme in two areas. Firstly, as a function of the groups as the participants interacted with each other. Secondly, social support was addressed in the sessions as a specific therapy target. Social support was not assessed with psychometric inventories in this study, but was a major component of two sessions, and was linked to the biopsychosocial model framework. It was expected that the participants' qualitative responses would disclose social support concepts as they were questioned specifically about the group's composition and relationships, and about session content. It was also expected that participants would gain support from each other psychologically, in terms of role modeling adaptive behaviours and problem solving difficult situations. Within the group process it was expected participants would experience reduced isolation and recognise they were not unique in their circumstances. By experiencing group social support and gaining new skills in managing their situation, it was expected participants' levels of distress would reduce.

CHAPTER 4 THERAPEUTIC GROUPS

The advantages of groups as a medium for imparting psychological therapy for individuals with a CHC are widely known (Burlingame & Beecher, 2008; Rose, 1980). For an historic overview of the development of group therapy including theoretical perspectives and orientations see Scheidlinger (2004). This chapter considers the literature on group processes, group structure, therapeutic factors and achieving change within a group setting. It also reviews groups as they relate to CHCs.

4.1 Definition of a Structured Therapeutic Group

A commonly held assumption in the literature is that a group exerts an influence on its participants and is a proven means or method for people to accomplish commonly held goals or aims. Garvin (1981) states groups have a similar purpose, and that is to prevent a decline in functioning, impart problem solving skills and use an intervention of some description. Although others exist, Scheidlinger, (2004) categorises four types of groups; Clinical Group Psychotherapy, Therapeutic Groups, Human Development and Training Groups, and Self-Help and Mutual-Help Groups.

Scheidlinger (2004) states a therapeutic group aims to attain the best possible outcome for individual functioning. However, Furman, Bender, and Rowan (2014) define a therapy group as a way “to help members explore their feelings, thoughts, and behaviours for the purpose of lasting change. Therapy groups can be short term or long term and often focus on a particular problem” (p 6). Further, Drum and Knott (2009) state that therapeutic or theme groups are “a time-limited, multi-session group

intervention exclusively focused on a developmental issue or resolution of a specific theme, issue, challenge, or problem common to the participants” (p 495). Schneider-Corey, Corey, and Corey (2014) comment that in groups such as this, the exchange and support among participants is critical for change to occur.

In addition, Drum and Knott (1977) define a structured group as a “delimited learning situation with a predetermined goal, a plan designed to enable each group member to reach this identified goal with minimum frustration and maximum ability to transfer the new learning to a wide range of life events” (p 14). Importantly, Beebe and Masterson (2009) state “such groups are led by professionals who are trained to help members overcome or manage individual problems in a group setting” (p 19).

4.1.1 Group structure.

Furman et al. (2014) comment the group should be large enough to foster a range and diversity of opinions, yet small enough to cultivate a sense of belonging. For adults, they suggest that an ideal size is between seven to ten members. Schneider-Corey et al. (2014) state eight members is an ideal number of participants for an adult group. Burlingame, McClendon, & Alonso (2011) comment that less than five members impacts negatively on group cohesion. Furman et al. (2014) and Schneider-Corey et al. (2014) agree group sessions should last up to two hours, with weekly attendance. Further, they suggest time limited duration, such as six meetings, is ideal in order to facilitate planning, target specific goals and allow for termination of the group. They cite a closed group which does not allow new members to join once the group has commenced, is preferable to an open group which allows new members to join at any stage. They state a closed group allows the participants to build greater cohesion and

trust with each other, which encourages rapport and in-depth disclosure. Other crucial group elements include group rules and confidentiality, and the use of ice breakers to help group members get to know each other. These elements reduce dropout rates and aid participants in finding commonality with each other, such as, shared emotions or common experiences (Furman et al., 2014; Schneider-Corey et al., 2014).

4.1.2 The health conditions psychology service therapeutic group structure.

Based on the literature, a closed structured therapeutic group with weekly sessions of two hours duration was selected as the format for the HCPS manualised group treatment programme. A central consideration in this study was whether quality of life improved and levels of distress were reduced. The therapeutic group was designed to conform to therapeutic guidelines and was interactive in nature. The group was designed to help participants gain skills, problem solve and address difficulties. These would be gained not only from the expertise and skills of the clinicians, but also from the experiences of group participants, and from the structured therapeutic tasks outlined in the manual. Each participant in the group identified that their attendance was due to psychological difficulties that they were experiencing as a result of living with a CHC. How the group processes evolved and how participants related to the group was also important, especially whether the group process may have enabled them to develop appropriate skills in a manner that would have a positive impact on them psychologically.

4.2 Stages of Development and Group Processes

Two concepts widely discussed in the literature are group stages and group processes. Group stages of development and group processes describe patterns of relationships among the group members which are conducive to further group development.

4.2.1 Group stages.

As a group progresses from the initial session through to completion, the group experiences patterns of exchanges or turning points which are commonly known as group stages. Group stages do not necessarily occur in order or predictably, and can be very fluid in nature. Although others exist, Schneider-Corey et al. (2014) describes group development as occurring in five stages. These stages comprise of the pre-group stage, the initial stage, the transition stage, the working stage and the final stage. They describe the pre-group stage as including the selection of participants and the planning, development and organising of the group. In the initial stage, members conduct themselves in what they consider a socially appropriate manner. As the group interacts, anxiety and uncertainty ensue. Thus, this stage is marked by the development of group norms as members orientate themselves and explore the group. The transition stage helps members to begin to interact in a deeper more meaningful way. Members explore trust with other group members and make decisions on whether or not to open up. During the working stage, group productivity and exploration increases. Also, during the working stage, the quality and depth of exchanges within the group increases. In the

final stage, group members identify and integrate learning that has occurred throughout the sessions, and deal with separation from the group (Schneider-Corey et al., 2014).

4.2.2 Group processes.

One of the central areas of exploration in group research remains the question of how individuals achieve change within a group setting. A basic assumption underlying group processes is that people will behave differently within groups compared to outside of a group. In the literature there are numerous definitions and descriptions of group processes.

Schneider-Corey et al. (2014) define group processes as the dynamics that govern the group interactions and how they are manifested. They state group processes consist of cohesion, trust, and how resistance and conflict occur in the group. Furman et al. (2014) state task and maintenance structures are key elements which occur in group processes. Tasks are defined as what the group is aiming for; while maintenance focuses on how the aims are achieved. Garvin (1981) lists five processes which occur between participants within groups. The first process is communication which considers who said what to whom, and under what circumstances. The next process is the sociometric structure which addresses who liked or disliked whom within the group. The third process identified by Garvin (1981) is the power structure within the group and who influences whom, and in what way. The fourth process concerns the leadership structure which develops within the group. This is based upon which individual is accomplishing most of the group tasks or who is working the hardest. The last process centers on roles. These may be official roles, such as a group leader, or unofficial roles based on characteristics of a person, such as, the group comedian (Garvin, 1981).

Achieving client change is fundamental in all clinical practice. Yalom's therapeutic factors (Yalom & Leszcz, 2005) have been widely cited and influential in identifying how the group process brings about improvement for clients. Essentially, the therapeutic factors emerge during the group process. The more factors present during the sessions, the more overall positive outcomes ensue. The individual, group members, and facilitators all influence whether these factors emerge. Table 1 (next page) outlines the therapeutic factors, with a brief description of key characteristics and the stage in which they predominantly (although not exclusively) occur.

As well as the therapeutic factors and group processes mentioned previously, other factors exist in the group process literature that is relevant to this study. These include group cohesion, participants' characteristics and facilitators' characteristics which are discussed in the following sections. Specifically, how these particular group processes may have impacted on participant change.

Table 1*Yalom's Curative Therapeutic Factors (Schneider-Corey, 2014; Yalom & Leszcz, 2005)*

Therapeutic Factor	Stage Occurring	Key Characteristics
Installation of hope	Beginning Phase	Faith the therapy will help. Enables individual to continue attendance so that the therapy can be effective
Universality	Beginning Phase	Disconfirmation of feelings of uniqueness. Realising they are not suffering alone
Imparting information	Beginning Phase Middle Phase	Formal instruction, psycho-education. Includes direct advice and didactic instruction
Altruism		Members gain in self-esteem by helping other group members
The corrective recapitulation of the primary family group		Members learn to interact in a more healthy manner rather than functioning in a manner reminiscent of their family of origin
Development of socialising techniques		Social learning and developing basic social skills
Imitative behaviour		Group members learn behaviours from observing group leaders and other group members
Interpersonal learning	Middle Phase	The group members learn to develop distortion free or more adaptive relationships based on understanding interpersonal relationships, corrective emotional experiences and the group as a microcosm
Group cohesiveness	Beginning Phase Middle Phase	Member feels part of the group and connected to other participants
Catharsis	Middle Phase	Being able to share and experience strong feelings
Existential	Beginning Phase	Confronting and recognising human frailty

4.2.2.1 Group cohesion.

A primary rationale for therapeutic groups is that it provides an important setting for establishing beneficial social relationships in treatment. Because participant to participant relationships and member to group relationships are considered one of the primary therapeutic mechanisms, an important construct is the concept of group cohesion (Yalom & Leszcz, 2005). A body of research supports the concept that the quality of group cohesion is correlated directly to eventual group outcomes (Burlingame et al., 2001; Gallagher, Tasca, Ritchie, Balfour, & Bissada, 2014; Yalom & Leszcz, 2005). Cohesion is a group's ability to work and relate to each other (Burlingame et al., 2001).

According to Burlingame et al. (2001) the construct of cohesion is complex and difficult to define. But it includes two fundamental dimensions of relationship quality and relationship structure, and encapsulates the essence of the relationships in a group between all of the members including participants and leaders (Burlingame, Cox, Davies, Layne, & Gleave, 2011). Group cohesion affects members' ability to relate to each other, leads to more meaningful interactions, promotes disclosure, and helps members tolerate potential conflicts within the group (Burlingame et al., 2001).

Moderating factors affecting group cohesion include intrapersonal and interpersonal concepts. Intrapersonal elements include a sense of belonging and acceptance, such as attachment anxiety (Gallagher et al., 2014). Interpersonal concepts include factors like compatibility among the group members, and collective commitment to the group. An example of this is forming impressions of each other and the apprehension felt at the beginning of attending a group (Marcus & Holahan, 1994).

4.2.2.2 Client characteristics.

Client characteristics such as personality and personal attributes are regularly investigated in group research as research consensus recognises that these factors affect outcomes (Fuhrman, & Burlingame, 1990). Crowe and Grenyer (2008) found in their study on depression that the participants' perception of the therapist alliance was not related to outcomes. However, group processes, such as the levels of conflict in a group, and the members' ability to work actively in treatment, predicted outcomes (Crowe & Grenyer, 2008).

Piper (1994) reports on two areas of client characteristics, namely, the persons' expectancies and the persons' interpersonal approach. Both are predictive of group process, attrition, and outcome (Piper, 1994). Yalom & Leszczk (2005) state client intrapersonal skills are important. These skills include having a capacity to examine their interpersonal behaviours, introspection, valuing personal change, being highly motivated for group work and genuinely desiring treatment. Furthermore, a person's interpersonal approach is also significant. Interpersonal characteristics include how a person interacts with others, is able to self-disclose, and has the capacity to be able to give and receive feedback (Yalom & Leszcz, 2005).

Baker, Burlingame, Cox, Beecher, and Gleave (2013) consider that client characteristics are indicators of group "readiness" and suggest group clinicians consider these in their group preparation. Further, they state clinicians should monitor participants during the early stages of the group to reduce potential drop-out rates and session non-attendance. Yalom and Leszcz (2005) report participants are more likely to drop-out of groups because of general dissatisfaction with the group experience.

Further, participants who dropped out also display characteristics such as having problems with intimacy, lower psychological mindedness, lower motivation, are reactive rather than reflective, have less positive emotion, experience greater denial, have substance abuse problems, express greater anger and hostility, possess lower intelligence, and have a lower understanding of how a group works (Yalom & Leszcz, 2005).

4.2.2.3 Facilitator characteristics.

Group psychotherapy research has also identified general facilitator characteristics. Research has focused on how group members consider the group facilitator and the alliance with the facilitator, the characteristics and attributes of a facilitator, and the impact of leadership on group processes.

Group members place facilitators in a central position, and at the start of groups are dependent on the facilitators. Members assume the facilitators are skilled, knowledgeable and have responsibility for the group (Garvin, 1981). Furman et al. (2014) comment that the facilitator has many roles such as being an active listener, sharing information, helping members make connections with each other, reflecting and guiding group discussions, and aiding the development of insight. They maintain that a facilitator empowers the group by balancing, and being directive, but not taking over the group. An important task they state is the need for the facilitator to reflect on their role in the group, and their overall participation. Facilitators need to have a clear idea of what causes change and what therapy would facilitate that change (Furman et al., 2014). Schneider-Corey et al. (2014) report that the key personal characteristics of a facilitator include adaptability, a willingness to model change, display genuineness, have a belief

in the group process, and show openness and empathy with participants. As a facilitator they need to be able to link material to group processes, including their therapeutic alliance with individuals, and confront, support and assess participants' responses throughout the sessions (Schneider-Corey et al., 2014).

The HCPS used two clinicians who co-facilitated the therapeutic groups. Luke and Hackney (2007), in their literature review on co-leadership, comment it is unclear whether co-leadership is more or less effective than single leadership. Current research into co-leadership is inadequate. However, benefits for co-leadership of groups have been identified. Schneider-Corey et al. (2014) state having a second facilitator allows an opportunity for a more in depth observation of the group participants and group processes to occur. It provides an opportunity to offer feedback on participants' progress, and helps facilitators by being able to add to each other's interventions. On a practical level, having co-leaders means there is help available if there is a problem with a participant or they need individual attention. Also, the group can continue if a leader is absent. They suggest facilitators need to have a high degree of interrelatedness to avoid potential problems occurring between the leaders. Also, co-leading a group requires planning and discussion prior to the sessions, especially concerning what issues are expected to arise (Schneider-Corey et al., 2014).

4.3 Groups and Chronic Health Conditions

Group studies involving CHCs have commonly focused on health outcomes rather than group processes and group structure. Perlman et al. (2010) report group programmes promoting improved psychological health and managing a CHC are common. But, in their literature review Fisher et al. (2007) comment that few studies

which evaluated CHCs, and in particular diabetic group therapy, exist. Daubenmier et al. (2007) in their Multisite Cardiac Lifestyle Intervention Program had a sample of 896 participants. They use group therapy and group support to facilitate treatment adherence. They found a significant reduction in cardiac risk occurred when stress reduction techniques were incorporated and implemented into their programme. These include guided imagery and progressive relaxation. In another study using group therapy for four CHCs, Spurgeon et al. (2005) found significant and sustained benefits across all four CHC groups improved coping behaviours, reduced anxiety and depression, and reduced General Practitioner service use. However, their 261 population sample had a bias. Only 36% of the population included were male participants. This reflects significant gender disparity issues in the uptake of care and poorer health outcomes for men (Coustasse et al., 2008). Moreover, participants who did not attend at least five sessions were excluded from their study, but they make no mention of how many people were excluded or dropped out of the study (Spurgeon et al., 2005). Ringsberg, Lepp, and Finnstrom (2002) asked their group participants with asthma symptoms only one research question; “what they achieved by participating in the program.” Participants reported they benefited from the solidarity they felt with the group, their self confidence increased, and they benefited from new strategies aiding coping with asthma. However, this question primed participants’ responses as it assumed all of the participants would have experienced a positive outcome from attendance. Despite reporting that solidarity occurred within the group, the study did not identify what group processes may have aided these outcomes.

Given the increase in CHC and groups designed to manage and treat psychological and physical symptoms, research which considers the impact a CHC may have on group processes and group structures remains scarce.

4.4 Summary

This chapter considered therapeutic groups and the literature on group structure, stages of group development, and group processes. It considered some of the therapeutic factors that aid in achieving change within a group setting including group cohesion, client characteristics and facilitator characteristics. It also considered CHCs group literature and the scarcity of studies considering the impact a CHC may have on group processes.

The manuals were implemented in a group setting, but a rational decision was made not to focus on or assess group process and therapeutic change in this study in a formal manner. This is because the same processes do not necessarily occur in a structured group as they do in an unstructured open ended group. Further, both the participants and clinicians were asked about how the groups functioned, so it was expected they would discuss group processes in their interviews. Also, it was important not to add undue burden to the clinicians taking the groups, who were implementing the manual for the first time and were novice group therapists. However, as this study is evaluating a manualised group treatment programme, it is important to ascertain qualitatively how the group functioned, and whether it had any impact on participants' outcomes.

CHAPTER 5 QUALITY OF LIFE

Quality of life performs an important role in maintaining the psychological health and well-being of people with CHCs. It was an important construct in the development of both treatment manuals and influenced the selection of therapy tools. A level of psychological dysfunction is required for a person to be referred to HCPS. In this situation a case formulation and concepts such as quality of life are of more use in treatment provision, rather than treatment provision decisions being reliant on meeting a mental disorder diagnosis such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV (APA, 1994) and DSM-5 (APA, 2013).

Chapters 5 and 6 consider the concepts which comprise quality of life and psychological distress. Quality of life and psychological distress in CHC are multifaceted, and to cover all significant aspects of these concepts is beyond the scope of this study. The existing literature considers both quality of life and psychological distress and often links both constructs together in numerous CHC studies. A basic assumption in most of these studies is that both coexist. A person's quality of life is impacted and functionality is reduced by increased levels of psychological distress. However, identifying specific associations between these constructs and how they impact on disease functionality and wellbeing are problematic, and seldom well-defined in the research. This is because quality of life research includes concepts based on philosophical, economic, sociological, psychological, and medical approaches, and focuses on how disease severity and aetiology impacts on adjustment to illness (Chaniotis, & Chaniotis, 2012). On the other hand psychological distress includes

constructs related to mental wellbeing such as anxiety, depression and stress. It was decided to consider these constructs separately in the development of the manual and in this literature review. This was because quality of life was not a specific treatment target in the treatment manual, but was considered to be a valuable outcome measure for the research project. Conversely, psychological distress was considered as a specific target of intervention within the manual.

Factors which impact on a CHC, were selected in terms of their relevance, to be incorporated into the manualised group treatment programme. Both quantitative and qualitative research in the health field on the topic of quality of life was examined for this study. The research focused on both objective and subjective experiences related to health outcomes in the field of CHCs. Targeted conditions included cardiovascular disease, diabetes, asthma and COPD.

5.1 Definition of Quality Of Life

The World Health Organisation (WHO) (1997) defines quality of life as a broad ranging concept regarding an individual's perception of their position in life. WHO (1997) report that quality of life is affected in a complex way by a number of factors such as a person's physical health, psychological state, level of independence, social relationships, personal beliefs and the context of the culture and value systems in which they live. Sprangers and Schwartz (1999) discuss quality of life in terms of the capacity of a person's ability to achieve their life plans, including their hopes and expectations. Brundtland (2001) suggests good mental health was important for quality of life. Sarafino and Smith (2011) define quality of life as a multidimensional concept that includes subjective factors such as life satisfaction, well-being, happiness, coping, and

adjustment to illness. It also includes objective concepts such as economic impact, physical self-care, the control of symptoms, and the absence of pain (Sarafino & Smith, 2011). The diverse definitions and variability for the use of quality of life in research is partly due to the way in which data is collected, analysed and reported (Wilkinson, Whitehead, & Ritchie, 2014). Despite difficulty concisely defining quality of life as a concept, the study of quality of life has enabled a wider understanding of CHCs and their impact on individuals.

5.2 Quality of Life and Chronic Health Conditions

Quality of life concepts are frequently used to identify a person's health functioning, and often affect treatment decisions when an individual's health functioning declines. Quality of life measures have been developed and widely used to evaluate the impact of different types of treatment in both biomedical and psychological functioning. It is also used to identify components of effective health interventions. Thus, quality of life research outcomes have implications on policy development and on health care treatment. Brundage et al. (2011) state quality of life is frequently used to give an overall picture of a person's health and well-being. However, gaps exist between research and clinical application, and a CHC and other experiences can widen that gap (Brundage et al., 2011). Overall, a basic assumption of quality of life research is that an increase in health functioning improves quality of life.

Furthermore, a CHC by its very nature of being an illness can lead to a focus on negative aspects of health, rather than recognising strengths, resilience and aspects of an individuals' life that could aid adaptation. Therefore, a core stance taken in the development of the HCPS manualised group treatment programme, was to focus on

therapeutic tools which could build on participants' existing strengths and improve their quality of life and adjustment to living with a CHC.

5.2.1 Quality of life and cardiovascular disease.

Fotos et al. (2013) report that in comparison to the general population individuals with cardiovascular disease experience poorer quality of life. Well known social factors that impact negatively on quality of life include age, gender, socio-economic and marital status and non-availability of helpful social support. Several physical factors are also recognised as impacting negatively on quality of life including the seriousness of the disease and the presence of multiple CHCs. Psychological difficulties such as depression and anxiety are also common (Fotos et al., 2013). In their literature review Falk, Ekman, Anderson, Fu, and Granger (2013) stress the impact fatigue and dyspnoea cause with cardiovascular disease. The effect can impact on quality of life and day to day living, reducing a person's independence and making them reliant on others for care. Further, poor health literacy and communication difficulties, such as the use of complex terminology, can be a problem which reduces effective self-management and symptom monitoring. Quality of life is impacted by distress symptoms such as hopelessness, sadness and low mood. However, O'Neil (2013) suggests co-morbid depression and heart disease and their impact on quality of life remain under-researched and focus on clinical outcomes. In their literature review Foxwell, Morely and Frizelle (2013) examined illness perceptions, quality of life and mood in a heterogeneous sample of CHC individuals. Consistent in the literature were findings suggesting a significant relationship exists between worsening illness perceptions, poorer quality of life and elevated levels of depression and anxiety.

5.2.1.1 Psychological treatment for cardiovascular disease.

Goodman, Firouzi, Banya, Lau-Walker, and Cowie (2013) suggest that psychological treatment that targets changing a person's perception of their illness is important in the treatment of cardiovascular disease. Individuals may feel they lack the personal means to bring about effective control and behaviour change. Therefore, psycho-education and psychosocial support are crucial to improving quality of life. Motivational interviewing techniques which develop self-efficacy, learning from others, and increased psychosocial support have been shown to be effective at improving quality of life in cardiovascular patients. Goodman et al. (2013) also report that removing barriers to treatment care and adherence, such as poor communication between the person and health professional, promote self-efficacy and self-care, and improve quality of life (Goodman et al., 2013).

Another psychological intervention is relaxation. As a behavioural therapy relaxation has a psychological and physiological effect. Psychologically it helps to reduce stress, aids a sense of symptom control and improves a sense of social well-being. Physically, relaxation has an effect on the parasympathetic system reducing cardiac workload (Jacobson 1970; Peveler & Johnston 1986).

Other psychological interventions include motivational interviewing which targets increasing activity, quantity, and type. This can aid in establishing a healthy lifestyle by giving participants insight into the positive effects of behaviour change (Chair et al., 2013) and improving positive social support (Chung, Moser, Lennie, & Frazier, 2013).

5.2.2 Quality of life and asthma.

Rand et al. (2012) suggest asthma research lacks outcome studies which would aid in the comparison and evaluation of therapies. They identified psychological factors which can affect asthma. These include exposure to psychological stress, such as negative life events, perceived stress such as financial difficulties, and mood such as anxiety and depression.

Asthma has a wide range of medical treatments, yet some individuals continue to have poor control, which negatively influences their quality of life, despite research suggesting self-management improves outcomes (Andrews, Jones, & Mullan, 2014; Avallone, McLeish, Luberto, & Bernstein, 2012). Anxiety symptoms and disorders such as panic attacks and panic disorder are commonly associated with asthma, with prevalence ranging from 16 to 25% for anxiety and 14 to 41% for depression compared to individuals without asthma (Urrutia et al., 2012). Tentative links have been made between poor control of asthma symptoms and a lack of adherence to medication, leading to an increase in depressive symptoms and reducing quality of life (Yonas, et al., 2013). In their literature review Andrews et al. (2014) contend treatment continues to focus on medical solutions, despite research suggesting asthma self-management should encompass psychological and environmental factors as well.

5.2.2.1 Psychological Treatment for asthma.

In their literature review, Prem, Sahoo, and Adhikari (2013) found that breathing exercises improved asthma control. However, their study was limited by the fact that their review included only three studies on diaphragmatic breathing. Also, an

assumption they made is that improvement shown in the studies was due to the breathing component, rather than for example, relaxation caused by the activation of the parasympathetic system. Nevertheless, limited research supports the use of diaphragmatic breathing (Prem, Sahoo, & Adhikari, 2013). In a more comprehensive literature review involving thirteen studies, Freitas et al. (2013) commented breathing exercises are a safe intervention with limited but not conclusive support, that breathing exercises may have positive effects on asthma symptoms and quality of life. Other psychological interventions like CBT and mindfulness therapy, have been shown to affect quality of life by reducing asthma symptoms and improving treatment adherence (Pbert et al., 2012). In their literature review Kaptein et al. (2008) report illness perceptions about asthma and its treatment affect outcomes. Further, teaching individuals self-management and coping skills are important components to improving quality of life.

5.2.3 Quality of life and diabetes.

Diabetes type 2 has rapidly grown to become a prevalent CHC causing concern for health services globally. In both type 1 and type 2 diabetes studies, psychological distress including depression and anxiety disorders have been associated with poorer metabolic control and increased risk of future complications. Unlike most other CHCs, individuals are confronted with the constant need to monitor their condition and make continuous decisions regarding care and treatment (Forlani et al., 2013). A significant issue is highlighted by Speight, Reaney, and Barnard (2009) in their review. Defining and measuring quality of life in diabetes control, treatment, and management is problematic. Currently quality of life definitions are not universally agreed upon and

remain ambiguous. The use of a number of indicators measuring quality of life, have led to confusion about research results and hinder comparative studies.

Psychosocial interventions have been considered an important adjunct to drug therapy in diabetes management. However, treatment adherence remains a significant issue (Koetsenruijter et al., 2014). Schofield, Cunich, and Naccarella (2014) conclude in their review that more rigorous research needs to be conducted to determine treatment effectiveness, and better health outcomes, and especially whether treatment is cost effective.

5.2.3.1 Psychological treatment for diabetes.

Magwood, Zapka, and Jenkins (2008) and Speight et al. (2009) assert difficulties exist and defining quality of life is essential in order to achieve better treatment outcomes. While interventions vary, many include multiple components or strategies but these are poorly described and broad in nature. According to Adili, Larijani, and Haghighatpanah (2006) psychosocial issues influence people's ability to manage their diabetes. They suggest as many as 40% of people with diabetes have significantly elevated levels of depressive and anxiety symptomatology, although they may not meet clinical criteria.

Psychological treatment for diabetes focuses predominantly on treatment adherence as well as mood and self- management. Interventions frequently use problem identification and problem solving skills (Forlani et al., 2013). Increasing positive social support is also a frequent target for psychological therapies. Research has demonstrated increased levels of social support improve both glycaemic control and quality of life

(Nash, 2013). CBT has been reported as improving outcomes. However, evidence for the effectiveness of CBT in diabetes care is meager as few studies use randomised controlled trials and many have small or unrepresentative samples (Adili, et al., 2006).

5.2.4 Quality of life and COPD.

COPD is a constellation of respiratory diseases which are usually progressive and characterised by airflow restrictions that cannot be reversed. These groups include chronic bronchitis, emphysema, asthma, and bronchiectasis. Symptoms include breathlessness, wheezing and coughing (Downs & Appel, 2007).

Asuka et al. (2013) report nearly a third of annual deaths globally are caused by COPD. The primary symptom of COPD is dyspnoea and this can lead to poor nutrition, decreased exercise capacity and resultant muscle atrophy. Psychological difficulties such as depression and anxiety are common, and further exacerbate the physical symptoms of COPD. Nearly half of individuals with COPD display depression symptoms which impact on quality of life, especially among those with greater illness severity (Asuka et al., 2013).

5.2.4.1 Psychological Treatment for COPD.

Heslop (2014) reports the psychological management of COPD remains under researched and utilised. They have found that psycho-education is the predominant psychological treatment with effective topics including; targeting smoking cessation, relaxation skills, goal setting, improved social support and coping with setbacks, being shown to be effective (Heslop, 2014). Indeed, Apps et al. (2014) concur, and for people with mild to moderate COPD, suggest utilising social support and increasing knowledge

of COPD are important for long-term self-management. In their systematic review Baraniak and Sheffield (2011) state results concerning the effectiveness of psychological therapies remain unclear due in part to the scarce amount of research. However, some research exists regarding the effectiveness of psychological interventions for anxiety such as progressive relaxation techniques (Baraniak & Sheffield, 2011). Kaptein, Fischer, and Scharloo (2014) also state self-management care in COPD remains underutilised and under researched. However, neither literature reviews comment why this is the position given the severity and prevalence of COPD, and what possible solutions are required to remedy the lack of research.

5.3 Summary

This chapter briefly reviewed quality of life and the impact it has on CHCs including cardiovascular disease, asthma, diabetes and COPD. It also considered psychological interventions which target improving quality of life for individuals with a CHC.

CHCs are recognised as being complex and multidimensional, and quality of life constructs are difficult to define and measure. Despite recognised limitations in quality of life research and measurements, agreement exists that over time the effect of ongoing issues with a CHC impact on disease symptoms, resulting in reduced quality of life. Quality of life is an important area to address in CHC psychological treatment, and participants are often referred to the HCPS for treatment to improve their psychological well-being and quality of life. Thus, treatment is needed that can help clients reduce their psychological difficulties, and improve their quality of life through increased coping and CHC management. The manualised group treatment programme recognises

how people feel about their health is important. Therefore, the therapy focuses on an individual's strengths and what participants can do, which allows them to make realistic and accessible goals. It also provides an environment where participants can discuss their concerns with others who experience similar issues and understand their problems from a similar perspective.

The first three chapters in the literature review considered topics which were assessed qualitatively. Both Quality of life and the following chapter on distress are important topics in the evaluation of the manualised group treatment programme as they were assessed quantitatively with psychometric inventories.

CHAPTER 6 PSYCHOLOGICAL DISTRESS

Mental health services exist for individuals in the Mid Central District Health Board region who meet criteria for mental health disorders, such as clinical depression and anxiety. The referral criterion for the HCPS is for clients experiencing psychological distress as a result of living with a CHC. Also, clients may exhibit other psychological symptoms which do not meet criteria but nevertheless cause significant issues in the clients' psychological well-being. While clients may meet DSM- IV and DSM-V criteria for a depression or anxiety disorder at the time of service use, the predominant referral criteria is for support related to having a CHC. This chapter reviews the literature regarding psychological distress and considers psychological therapies which target reducing levels of distress.

6.1 Definition of Psychological Distress

The term psychological distress is widely used in health and social psychology, but overt definitions of the concept are difficult to locate. The term implies distress is a result of stressful events or impact of a CHC. The way people adapt, manage and make sense of their CHC is dependent upon their cognition, resilience, and coping abilities. How they perceive their illness affects their self-care and other factors such as adherence, and when these are challenged beyond a person's capacity, then distress is the result (Palgi et al., 2014). Psychological distress according to Gan, Nasir, Zalilah, and Haziz (2012) contains constructs such as anxiety, anger, stress, and sadness. Elevated levels of psychological distress have been found in people with CHCs in

comparison to healthy controls. Psychological distress has been shown to influence back pain and spinal surgery outcomes (Patton et al., 2012), eating disorders (Gan et al., 2012), and in rheumatoid arthritis there is a close association with pain and psychological distress (Benka et al., 2012).

6.2 Psychological Distress and Chronic Health Conditions

In a New Zealand context a disparity of psychological distress exists between different population groups. Krynen, Osborne, Duck, Houkamau, and Sibley (2013) report that Pacific Nations peoples are most at risk of having (or developing) an anxiety disorder or depression (12.9%), followed by Māori (10.8%), Asian (7.7%), and European/Other (6.1%). However, it is unclear how psychological distress as a specific entity impacts on CHC prevalence in New Zealand.

While the effects of disease on levels of distress have been extensively reported, disease status alone cannot fully explain the variance in psychological functioning that occurs with individuals affected by psychological distress. Several modifiable risk factors also play a role in psychological distress including mental health, activity levels, social support, physical health, sleep and alcohol consumption (Atkins, Naismith, Luscombe, & Hickie, 2013).

For the purpose of this study the term psychological distress is used rather than depression and anxiety for a number of reasons. Individuals who meet the DSM-IV and DSM-V criteria for anxiety and depressive disorders receive mental health services through other local providers within the MidCentral area. It is important to remember that often the categorical use of diagnostic criteria such as these is used by healthcare agencies to report statistics as well as provide treatment. Also, there is difficulty with

CHCs separating depressive and anxiety symptoms from physical illness symptoms. For example, sleep and breathing difficulties.

6.2.1 Psychological distress and cardiovascular disease.

The direct and indirect links between the impact psychological distress has on cardiovascular disease has been validated in meta-analytic studies (Batty, Russ, Stamatakis, & Kivimäki, 2014; Nicholson, Kuper, & Hemingway, 2006). Further, levels of psychological distress increased the risk of a cardiac event even at low to moderate levels of distress (Batty et al., 2014; O'Neil, 2013). Pan and Rexrode (2012) report that over time psychological status is highly variable in cardiovascular disease. It is unclear whether there are differences between long-term or short-term exposure to psychological distress. Further, psychological distress consists of various mood states, and there are few standard procedures in place to screen and treat psychological distress in primary health care settings, despite its significant risk. Additionally, O'Neil (2013) in her literature review contended the nature between the two is reciprocal rather than causal in nature. Other problems she identified include increased suicide rates, reduced health care utilisation, and reduced medical adherence to treatment. Thus, understanding the role of psychosocial factors in cardiovascular disease is crucial for both prevention and treatment (O'Neil, 2013). Research supports the link between depression and anxiety symptoms, and high risk health behaviours such as smoking, alcohol misuse, poor physical diet and lack of physical activity. Dunbar et al. (2008), reports these risk factors are associated with both the onset of diabetes and heart disease. But, Volz et al. (2011) contend most studies consider only one or two psychological factors. Because many psychological constructs are highly correlated and overlap, research often

overestimates the effects of one variable and ignores the potential impact of other variables.

6.2.2 Psychological treatment for cardiovascular disease.

Research is lacking concerning how effective, and under what circumstances, psychological treatment can influence cardiovascular disease. However, a complex array of treatments exists, and evidence suggests psychological treatment reduces depression and anxiety levels but not necessarily mortality risk (Whalley, Thompson, & Taylor, 2014). Reid, Ski, and Thompson (2013) in their literature review also found only modest limited evidence for psychological improvement, and commented most of the small number of studies in their review were assessed as having poor methodology. However, primary health care and prevention has improved significantly over the last decade and it is unclear from recent research how this may have impacted psychological outcomes (Reid et al., 2013).

One established method with substantial evidence that reports improvement in health outcomes, including reduced cardiac risk, is the use of relaxation therapy. Non-physical relaxation therapies, such as visual or guided imagery have been shown to have a more psychologically calming effect. Physical relaxation techniques, such as progressive relaxation, have greater physiologic effects (Yu, Lee, & Woo, 2007; van Dixhoorn, & White, 2005).

6.2.3 Psychological distress and asthma.

Asthma has no cure. Instead, people with asthma are reliant on managing their symptoms. As with other CHCs, this presents difficulties for a number of people, and

the link between psychological distress and asthma is well established. Distress rates for asthmatics occur at double that of the general population and are connected directly to the severity of asthma, and a decreased ability to manage symptoms. In fact, suboptimal care is reported in around 7-8% of all asthmatics (Oraka, King, & Callahan, 2010). According to Schmitz, Wang, Malla, and Lesage (2009) asthma is associated with poorer quality of life, increased mortality, high health care use and increased loss of workplace productivity. Further, it is predictive of later onset panic disorder and other anxiety disorders (Tien, Goodie, Duncan, Szabo, & Larson, 2014). Ismaila, Sayani, Marin, and Su (2013) state depressive symptoms especially impact on asthma and are linked to asthma severity and worse asthma control. They comment that given the prevalence of psychological distress and the significant impact it has on asthma outcomes, they recommend psychological professionals should be part of a primary care team. In their New Zealand study Vamos and Kolbe (1999) found that despite the provision of education, practical knowledge of managing worsening asthma remained low amongst their outpatient population. Further, they mentioned that high levels of anxiety, including a fear of dying, amongst their group may have impaired self-management.

6.2.4 Psychological treatment for asthma.

Research supports that up to 25% of asthma triggers are the result of stress or emotional factors (Ritz, 2012). Therefore, psychological treatment has an important role in asthma management. According to Tien et al. (2014) psycho-education, progressive muscle relaxation, guided imagery, cognitive restructuring, and problem-solving training are all effective psychological treatments, which have resulted in a reduction in

psychological distress symptoms. Further, in their literature review on psychosocial and behavioural interventions, Ritz, Meuret, Trueba, Fritzsche, and von Leupoldt (2013) report self-management training, breathing training, and exercise or physical activation programmes have been proven effective in reducing asthma symptoms. Other interventions which have shown promising results require more study, including smoking cessation, dietary programmes, and biofeedback training (Ritz et al., 2013). Sarver and Murphy (2009) suggest understanding the asthma, adhering to medication and building a good relationship with health providers is essential in asthma care. They report the quality of the relationship with health providers and their patients has a direct effect on health care utilisation, treatment adherence and outcomes. However, patients report high levels of distrust and dissatisfaction with health providers. They recommend health professionals use guidelines and treatment plans (Sarver & Murphy, 2009), but this does not address the issue from the patients perspective and their need to develop communication and social support skills.

6.2.5 Psychological distress and diabetes.

Diabetes affects approximately 8% of the population with figures expected to increase globally (Baek, Tanenbaum, & Gonzalez, 2014). Life- long tasks of managing diabetes such as dietary restrictions, blood sugar monitoring and medication use including self-injecting, can increase levels of distress and create poorer emotional outcomes. Snoek et al. (2011) report that nearly a quarter of all people with diabetes present with a comorbid psychological distress or a mental health condition. Rubin and Peyrot (2001) contend psychological distress is chronic and severe in a significant

proportion of individuals with diabetes. They suggest relapses in depressive and anxiety symptoms are common.

As well as this, diabetes is a complex CHC that can affect and cause complications with a number of organs in the body including eye, kidney, pancreas, heart, sexual dysfunction and neuropathy (nerve damage resulting in pain in the extremities). Peyrot et al. (2005) indicate that psychosocial problems, for example poor social support, impose barriers on effective care. This includes daily self-management tasks such as diet and medication adherence. This may be related to social stigma which is another potentially significant psychosocial factor that may cause sub-optimal care (Schabert, Browne, Mosely & Speight, 2013).

6.2.6 Psychological treatment for diabetes.

Evidence exists for the use of Psychological treatment as an adjunct to medication for the support of hypoglycaemic control. Studies have reported on the effective use of CBT and motivational enhancement therapy which aims to modify depression and ambivalent adherence behaviour. However, according to Ridge et al. (2012), effect sizes were small and negligible at long-term follow-up after 2, 3 and 4 years. Rubin and Peyrot (2001) suggest biofeedback and other forms of relaxation are beneficial. Furthermore, Fisher et al. (2007) comment that individuals receiving problem-focused psychotherapy, relaxation skills, and techniques to improve social support, achieve improvements in psychological functioning and diabetes management, compared to a wait list control group.

6.2.7 Psychological distress and COPD.

While distress in a CHC is common, the incidence of distress in COPD has been noted as being one of the most prevalent among CHC. Karadag et al. (2008) state that in 58% of inpatients and 42% of outpatients with COPD, psychological distress is evident. Yohannes, Baldwin, Connolly (2006) report prevalence rates for anxiety occurs in 36% and depression occurs in 40% of the clinical population with COPD. Furthermore, high prevalence rates of distress have been associated with increased hospital admissions, symptom deterioration and increased mortality. Karadag et al. (2008) state the more severe the physical symptoms of COPD, the more severe the distress levels which occur. Pooler and Beech (2014) comment distress leads to more hospital admissions and acute exacerbations. This is a significant problem because lung functioning declines and frequently does not return to the same level as before an exacerbation, further negatively impacting on levels of distress. Moreover, active smokers with COPD are less likely to be treatment adherent as they face difficulty with continued addiction (Turan, Yemez, & Itil, 2014). Heslop (2014) suggests psychological distress remains poorly treated for patients with COPD, as focus continues to be placed on medical interventions rather than pulmonary rehabilitation and psychological interventions.

6.2.8 Psychological treatment for COPD.

Heslop (2014) states crucial components of psychological care for individuals with COPD include CBT, exercise, and pulmonary rehabilitation. However, Heslop (2014) does not report the origin of the research and the evidence supporting these treatment components. Fritzsche, Clamor, and von Leupoldt, (2011) in their review

comment that there is a lack of evidence for effective psychological treatment. They reviewed CBT which includes components that challenge automatic thoughts, enhance problem solving techniques, and sleep management. Behavioral components include enhancing current activities and relaxation and stress management techniques.

Fritzsche, Clamor and von Leupoldt (2011) suggest further evidence supporting CBT is needed and results were inconclusive. However, in their literature review Panagioti, Scott, Blakemore and Coventry (2014) found CBT and relaxation therapy reduced anxiety and depression levels and improved COPD outcomes, although the effect sizes were small.

6.3 Summary

Psychological distress is a significant risk factor for health outcomes, and was identified as being a significant reason for referrals to the HCPS. The HCPS recognises distress can include an extensive array of experiences ranging from relatively mild and temporary states, to more chronic and severe conditions. However, the HCPS does not duplicate other mental health services that exist locally.

Psychological distress has profound and serious implications for CHC care and is a significant risk factor in CHC outcomes and mortality rates. Research has identified the negative reciprocal nature of the disease impairment and increased levels of distress. Further, psychological distress is present in a significant proportion of individuals with a CHC.

Manualised treatments developed for CHCs frequently measure depression and anxiety constructs, as they suggest a level of measureable dysfunction often required by funding institutions. While direct comparisons to other manuals with this project was

not a specific objective, it was important to be able to generate data from the project which could be used to consider treatment effectiveness, in the light of the body of currently available research literature.

CHAPTER 7 THE DEVELOPMENT OF THE TREATMENT MANUALS

This chapter describes the development and contents of the pilot and the main well-being group treatment manuals for the HCPS. The manualised group treatment programme consists of a pilot manual and participants' workbook, and a main well-being group manual (see Appendix A) and participants' workbook. The workbooks were abridged versions of the two treatment manuals' therapeutic exercises, which were given to the participants as a practice tool. In developing and evaluating the manuals, the purpose was not to compare the pilot manual with the main well-being manual, but to develop and provide a manual which could be used in the Service.

7.1 The Development of the Manuals

The manuals were developed by the writer in consultation, with feedback and with suggestions from those involved in the project. This included feedback from both clinicians involved with the Massey University's HCPS and from the academic supervisors in the Psychology Department.

The initial literature review informed the development of the manuals. Thus, evidence based therapies targeting improved quality of life, and the alleviation of psychological distress were considered for inclusion. Accordingly, the manuals utilised research-supported treatments, practice guidelines and practice-based evidential therapies in a sequence which was designed to provide optimal impact for clients with a CHC. The manual was designed to provide a valid and consistent treatment procedure which could be used in therapeutic groups across multiple sites by different clinicians.

The final selection of content also emerged from the diverse multiple and complex needs of the client population in the HCPS area.

Further, implicit in the development of the manuals were two underlying principles. Firstly, that a specific illness or CHC was not the primary focus, rather the emphasis was on a wellness approach. Secondly, regardless of an individual's unique characteristics and circumstances, the therapeutic components used in the manuals were associated with efficacious outcomes. The manual was designed to be implemented flexibly according to the needs of the group.

From the research literature, a wide range of possible interventions, therapy goals and treatment targets were developed. Suitable therapies were revised and narrowed down to fit both the requirements of the HCPS and the needs of the health conditions clients seen at the clinic.

7.2 Theoretical Stance of the Manuals

The therapeutic elements used in the manuals originate from an eclectic theoretical approach rather than a singular theoretical stance. Vamos (2006) suggested that different techniques may be required in therapy to address the multifaceted nature of presenting issues. However, this creates issues with theoretical integration and treatment delivery in a naturalistic clinical setting. Primarily, it may cause a lack of cohesiveness, making it difficult for both clinicians and clients to understand the therapy and more importantly, the psychological change processes.

Walker, Jackson, and Littlejohn (2004) state three major frameworks or key theoretical areas exist in CHC literature, research and clinical practice. These are the biomedical, psychological and biopsychosocial models. Thus, to create a coherent and

logical linkage throughout both the manuals, a biopsychosocial model framework was used with psychological, physical, and social treatment components. The following sections outline these components along with an example of how they were used in the manuals. A more complete account of both manuals' content and the differences between the two are outlined later in this chapter.

7.3 Psychological Therapy Components

Walker et al. (2004) discuss research on the relationship between psychological functioning and CHCs. Psychological functioning has traditionally focused on depression and anxiety. However, psychological well-being, adjustment to illness and coping processes are also relevant. In both manuals, psycho-education was used as a psychological treatment component of the biopsychosocial framework. Psycho-education is a psychological tool which has been shown to reduce distress and anxiety (Brown, Cochrane, & Cardone, 1999). In their literature review, Lager, Pataky and Golay (2010) suggest that psycho-education in CHCs improves quality of life and physical symptom change. Furthermore, psycho-education enables individuals to develop competencies which can help change health behaviours. Moreover, psycho-education has also been shown to have a cumulative effect on the concepts and beliefs that clients hold about their health behaviours (Lager et al., 2010). An example of a psychological therapy component used in both manuals was psycho-education on the biopsychosocial model, and how it can be applied to CHCs.

7.4 Physical Therapy Components.

Esch, Fricchione and Stefano (2003) report that efficacy for stress reduction techniques is well established and reliable, as an appropriate intervention which can impact and prevent health decline. There is increasing evidence also that stress as the result of a CHC, has an adverse effect on overall health and well-being, as it impedes natural healing capacities. Further, they report that relaxation techniques are underutilised but are a pertinent and suitable therapy for treating stress related health conditions (Esch et al., 2003). In both manuals, relaxation therapy and biofeedback were used as a physical treatment component of the biopsychosocial framework.

Relaxation techniques such as diaphragmatic breathing, progressive muscle relaxation, visual imagery and biofeedback are widely used in clinical practice. Research suggests it is efficacious for anxiety, depression, diabetes, asthma and cardiac conditions (Reiner, 2008). Moreover, relaxation therapy decreases the resting heart rate. Individuals taught relaxation therapy have shown a decline in the incidence of angina, arrhythmias, cardiac events and cardiac death (Ziegelstein, 2007). Reiner's (2008) research also supports using biofeedback monitors as an effective treatment in targeting involuntary processes (e.g. heart rate or blood pressure) enhancing performance, or reinforcing correct diaphragmatic breathing which, in turn, reduces autonomic reactivity as an adjunct to various meditative or relaxation techniques.

7.5 Social Therapy Components

Cohen and Wills (1985) propose that CHCs can lead to a deterioration of perceived social support and social support networks. This becomes problematic

especially when an individual with a CHC is reliant on support from others to meet their needs (Schreurs & de Ridder, 1997). Further, social support is linked to health-related behaviours such as medical adherence and self-care. Social support can act as a buffer, offer an instrumental support or mitigate negative appraisals. By identifying a person's current existing social support, and assessing the quality of that support, individuals can potentially counter the adverse effects of stress and increase the perceived availability of interpersonal resources (Cohen & Wills, 1985). Furthermore, perceived social support has a positive influence on psychological adjustment and health outcomes, especially in cardiovascular disease (Penninx, Kriegsman, van Eijk, Boeke, & Deeg, 1996). In addition, Hogan, Linden, and Najarian (2002) report in their research that interventions targeting skills training, relationship building, and reciprocal social support show overall beneficial outcomes.

Reviews, such as van Dam et al. (2005), Graven and Grant (2014), Rabinowitz and Florian (1992), and Gallant (2003), suggest gaining effective social support from health professionals requires addressing, in order to improve illness management and outcomes. In both manuals the social component of the biopsychosocial framework focus is on improving communication and interaction with others. Integrating the clinical goals along with a person's real life environment can be problematic. It is crucial to gain the right or accurate information so informed decisions can be made. Achieving clear communication and interactions with health professionals is also essential but it can be difficult to realise (Marks, Allegrante, & Lorig, 2005). Likewise, achieving clear and open communication with health care providers is necessary for an

individual to manage, understand and subsequently adhere to their medical regimen and health care management (Diamond & Scheifler, 2007).

7.6 Evaluation of the Programme

Throughout the project's development and evaluation, it was important to scrutinize and think about underlying assumptions and activities. The manualised group treatment programme used programme evaluation described by Fitz-Gibbon and Morris (1987) and Patton (2012) as guidelines. Both evaluation guides suggest a programme evaluation should consider and consist of a number of features. These should include the development of a programme, its assessment, and the dissemination of the study's findings, as discussed below. This approach is consistent with other guidelines (Craig, et al., 2008)

Firstly, the developer must work closely and gain input from intended users and participants prior to the programme commencing. Meetings were held throughout this project as the manualised group treatment programme was being developed. It was important to discuss with the clinicians how they envisaged the programme would work in their Service and for their clients. As well as the manuals, a copy of the American Group Psychotherapy Association guidelines (Bernard et al., 2008) was given to the clinicians. Once a draft was complete, further feedback and suggestions were made including adding dialogue instead of using explanatory notes and guidelines for the therapeutic exercises. Once the pilot programme was finished, feedback from both participants and clinicians was sought.

Next, an evaluation study should be adequately developed including how the programme is implemented, what its outcomes are, and what cause is given to the

attribution of the results. Bower (2003) contended treatments shown to be efficacious in randomised controlled trials do not necessarily transfer to clinical practice with the same effect. Rather, effectiveness studies are required to understand how therapy works in a naturalistic environment (Campbell et al., 2000; Craig et al., 2008). Thus, effectiveness studies are concerned with treatment generalisability, rather than group assignment and comparisons with control groups. In order to gain evidence for programme effectiveness, how the manuals would be assessed and evaluated was important. The use of a non-equivalent control group design or comparative study using other manuals was deemed unsuitable for this study as they would be meaningfully different from the manualised group treatment programme. Further, it was expected that a number of groups would occur enabling the collection of sufficient data. Thus, a before and after design collecting pre and post treatment measures was selected. However, the disadvantage of this design is that it is difficult to ascertain what would have happened had this particular intervention not been used.

The last stage of evaluation is the dissemination of findings and reporting of results. The clinicians received feedback directly from participants during the groups; and a verbal summary of the results from both groups' semi-structured interviews conducted by the researcher, was also given to the clinicians. This thesis and conference presentations (Appendix K and L) were also used to present the report findings.

7.7 Pilot Manual and Main Well-Being Group Manual Session Layout

The session layout followed the guidelines explained in earlier chapters. Each two- hour session followed an identical layout and was guided by a closed structured group model proposed by Drum and Knott (1977). Both formal and informal, and group

and individual activities were used in each session to create learning situations which were designed to generalise to everyday living (Richards, Burlingame, & Fuhrman, 1990) and follow practice guidelines which were set out by the American Group Psychotherapy Association (Bernard et al., 2008).

The first part of each session was explanatory in nature. It included a short introductory statement giving an overview of the key concept for each session. This was followed by an outline of the session goals and clinician tasks. The material section followed next providing an inventory of the items required for each session (Bernard et al., 2008).

The next part of the session focused on group processes with activities that enhanced therapeutic group factors. Once the participants were welcomed and the session outline discussed, a structured group exercise was introduced. The structured group exercise varied for each session and was designed to engage members to join with the group, reduce premature drop-out rates and aid social support. Sessions two to six included a homework review section after the structured group exercise. Following the homework review, the therapeutic exercises were introduced. A refreshment break occurred at a convenient time between therapy components and after the break therapeutic activities would continue. The session ended with the administration of brief psychometric tests and the discussion of homework exercises prior to closing.

7.7.1 Pilot manual.

An overview of the therapeutic components in the 70-page pilot manual is as follows: using the biopsychosocial framework, sessions one and two focused on psychological interventions, sessions three and four focused on physical interventions,

and sessions five and six focused on social interventions. These were presented in a sequence designed to encourage logical sequential engagement by group participants.

7.7.1.1 Session one: acknowledging distress and increasing an awareness of strengths.

The purpose of session one was to help participants to identify their presenting problems and reinforce their existing personal strengths. Furthermore, it was the aim that at the end of the first session, participants should feel that attending further sessions would be helpful for their particular situation and circumstances. Also, the group setting should provide a place where they would experience an empathic understanding of their CHC.

Session one's therapeutic content explored finding solutions to current problems based on past successes. This began with the identification of current issues and difficulties. Next, participants identified past difficulties they had faced effectively including the approaches used to successfully manage their situation. The next part of the activity explored participants' values and beliefs which they may have abandoned or neglected in their current circumstances, possibly due to their health issues.

Towards the end of the session, the biopsychosocial model was introduced with an explanation as to how this is linked to health. An explanation of how health is impacted in a complex and dynamic way rather than considering CHC in a strictly biomedical framework was highlighted for participants.

7.7.1.2 Session two: Psychological and physical stress. Strategies to assist building strength and resilience.

Session two had multiple aims. Firstly, it was designed to reinforce an awareness of personal strengths that was discussed in the previous session. Next, it attempts to further aid participants to view or construct a future that focused on the positive aspects of their lives. Also, participants would have observed others living with a long term illness and recognised their choices, despite the limitations of living with a CHC. Another aim of session two was to introduce concepts that linked psychological well-being to physical health. Further, the session was intended to facilitate positive behaviour change through promoting an increased awareness of the reciprocal relationship between the mind and body, as explained by the biopsychosocial model.

The therapeutic content of session two began with the Magic or Miracle question (de Shazer, 1988). In particular, the Miracle question explored existing strengths and resources, and applied these to current difficulties faced by the participants. The next therapeutic tools used in the session consisted of psycho-education using the biopsychosocial model; learning the relationship between chronic stress, anxiety and depression; and the situations or events that exacerbate stress and impact on CHCs. Finally, diaphragmatic breathing, the first physical therapy component of the biopsychosocial framework, was introduced.

7.7.1.3 Session three: strategies for managing stress and distress.

Session three reinforced the physical component of the biopsychosocial model. This session aimed to increase the ability to attend to relaxation activities. Thus, participants experienced first-hand, the concept and physical benefits of relaxation, and

learned how to activate a relaxation response. Although it would not make the issue of living with a long term illness go away, reducing stress would help make a CHC more tolerable, as well as assisting participants to develop a sense of control in increasing their sense of well-being.

Session three's therapeutic content was solely based on learning the relaxation techniques of progressive muscle relaxation and visual imagery relaxation. These include the Sunlight Meditation (Bourne, 2005) and A Walk in the Country (Lorig et al., 2006).

Being able to maximise one's potential and gain a sense of self control, despite a health condition, is a dynamic and continuing process. The aim was that relaxation techniques would demonstrate the relationship between mind and body. In addition, it gave a practical demonstration of physiological changes which occur when people intentionally attempt to relax.

7.7.1.4 Session four: biofeedback.

The therapy content of session four focused entirely on a practical demonstration of using a biofeedback machine to illustrate powerfully, an individual's ability to have some control over physical aspects of their health and body.

7.7.1.5 Session five: communication with health professionals and identifying barriers to implementing change.

Under the biopsychosocial framework, sessions five and six focused on social support. The focus in session five was on acquiring knowledge and social skills which would reinforce a participant's ability to be responsible for their self-care and well-

being. Another aim was to empower participants to access required health information and to use this to make informed decisions. Thus, participants would actively manage their care, and persist in obtaining quality services from health providers by strengthening their sense of participation during interactions with health care providers.

Part of session five's therapy components was learning the acronym P.A.R.T. (Prepare, Ask, Repeat and Take Action) (Lorig et al., 2006). The next therapeutic intervention brainstormed health care system hints, and shared thoughts and ideas to assist in managing appointments and health care services. The final therapeutic intervention of the session was an introduction to the Stages of Change Model (Prochaska, Di Clemente, & Norcross, 1992).

7.7.1.6 Session six: building support.

The aim of session six was to consider the social support that participants gained in the group context, and to facilitate discussion about increasing positive social support in their personal lives following group completion. The session also focused on reviewing topics, ideas and skills that had been discussed and implemented throughout all the sessions.

The therapeutic content of this session focused on further developing existing social support. Participants considered a range of enjoyable leisure and recreational activities they could pursue to create opportunities to increase contact with others, and develop opportunities to improve their social support. Participants role-played scenarios and practiced using social skills. Finally, to end the session, a discussion was held on the positive changes that had occurred as a result of living with a chronic illness. The

session and group therapy closed with a discussion of highlights and a certificate (Appendix C) presentation.

7.7.2 Feedback from the pilot manual.

On completion of the group, participants and the two senior clinicians who implemented the pilot group manual were interviewed. Amendments to the main well-being group manual were made based on this feedback, and in consultation with those involved in the project.

7.7.2.1 Senior clinicians.

The clinicians made a number of recommendations. Firstly, there was too much content and whilst they implemented nearly all of the therapy, extra time to allow more in-depth exploration of some subjects would have been beneficial. Next, low participant numbers for the pilot group was a limiting factor as the clinicians experienced difficulty recruiting willing participants. This resulted in the clinicians being more active in group discussions rather than individual participants. Thirdly, minor changes were made in the manual layout for the ease of reading instructions. It was also recommended that the content of session one be reordered giving the biopsychosocial model more prominence and to link it more clearly to the therapeutic content. Overall, both the clinicians reported that the therapeutic content and the pilot group manual appeared suitable for treatment purposes.

7.7.2.2 Participants.

All of the participants who were interviewed were able to recall aspects of therapy that had assisted them and that they continued to use after the group had ended. However, a general comment was that it would have been beneficial to include motivational strategies enabling them to make changes in their lives. Notably, the only therapy component not administered by the therapists was during session five. This was the stages of change model. Further comments from the participants are included in the results section.

Both clinicians and participants commented that the manual was effective and helpful, thus amendments to the main well-being group manual were minor. The following section outlines the therapeutic changes between the manuals. Otherwise, the main well-being group manual remained the same as the pilot group manual.

7.7.3 Main well-being group manual.

Sessions one and two focused on psychological interventions, sessions three and four focused on physical interventions, and sessions five and six focused on social interventions. An overview of the therapeutic components in the 64-page main well-being group manual is as follows.

7.7.3.1 Session one acknowledging distress and increasing awareness of coping.

The aims of the first session were similar to the pilot group manual. That is, to identify presenting problems and existing strengths, to attend further sessions and to

receive an empathetic understanding from attending the group. In addition, the participants would have gained an understanding of the biopsychosocial model.

The first session's therapeutic content was the same as the pilot group manual with an exploration of current problems and finding solutions based on past successes. The main well-being group manual removed the activity based on values and beliefs, and focused on an expanded psycho-education section with examples of the biopsychosocial model of stress.

7.7.3.2 Session two: moving towards well-being by using the biopsychosocial model of stress.

The aim of this session was to use the biopsychosocial model of stress concepts linking psycho-social or mental well-being to improved physical health. Further, participants should be able to identify the concepts and symptoms of stress, anxiety and depression, and personal circumstances exacerbating their stress.

Therapeutic content focused on psycho-education on the biopsychosocial model of chronic stress, and the relationship between chronic stress, anxiety and depression. It also focused on psycho-educating what a participant should do if they are experiencing, or not coping with depression or anxiety symptoms.

7.7.3.3 Session three: strategies for managing distress.

The aims for session three remained the same as the pilot group manual's version. Namely, the physical component of the biopsychosocial model was reinforced through the use of relaxation activities.

Session three's therapeutic content introduced diaphragmatic breathing (session two in the pilot version) and Sunlight Meditation (Bourne, 2005). Other forms of relaxation such as visual imagery were removed as the clinicians reported they did not have enough time to fully administer all of the relaxation exercises.

7.7.3.4 Session four: biofeedback and session five: communication with health professionals and identifying barriers to implementing change.

Sessions four and five remained the same for both the pilot group manual and the main well-being group manual.

7.7.3.5 Session six: building support.

Session six remained the same as the pilot group manual. However the exercise of considering enjoyable activities was removed due to the large amount of content in this session and the previous coverage of increasing social support was deemed sufficient.

7.8 Summary

This chapter described the development and contents of the pilot group manual and the revised main well-being group manual. This programme was used by the group participants with CHC through Massey University's Psychology Clinic HCPS in Palmerston North. The Psychology clinic is a teaching clinic which trains both health and clinical psychology students. Thus, the manual had to be fit for use for a wide range of staff including training students, novice therapists as well as experienced clinicians. While a number of self-help and community group based psycho-educational groups

exist, clinical manuals for use in a therapeutic manner are scarce, especially for a range of CHCs. Also, most programmes assume their participants face the same challenges and will respond to treatment in the same way. The aim of the manualised group treatment programme was to create a treatment which could be used in the HCPS.

CHAPTER 8 METHODOLOGY

8.1 Outline and Aims

This chapter outlines the research design, data collection, participants, procedures, ethics considerations and the methods used in this research project.

The initial aim of this study was to evaluate the effectiveness of a manualised group treatment programme for clients with a CHC and to aid the HCPS in its decision making process. The manualised group treatment programme used psychometric results to ascertain whether the participants' quality of life improved and whether their distress levels reduced. It also explored the participants' and clinicians' experiences of being part of the manualised group treatment programme. The research questions included:

Was the manualised group treatment programme effective in improving quality of life and reducing distress in clients with a chronic health condition? What were the participants and clinicians experiences of the groups?

8.2 Study Design

The study used a mixed methods approach to answer the research question and examined both quantitative and qualitative data generated by the study. The rationale of using a mixed methods approach, according to Yardley and Bishop (2008), is to elaborate and provide a richer and more comprehensive description of a phenomenon and allow for deeper interpretation of participants' experiences. The quantitative results used a before and after design collecting pre and post treatment measures. Due to the nature of the HCPS, it was deemed inappropriate to conduct a randomised controlled

trial. Randomised controlled trials are considered the gold standard for producing rigorous cause and effect relationships required as evidence for treatment efficacy in clinical research (Sibbald & Roland, 1998). Firstly, all of the clients required treatment therefore it would be unethical to place clients into a non-treatment group. Also, the large number of participants required to conduct a randomized controlled trial was beyond the scope of the HCPS. The increase in the number of clients would require an expansion of the Service beyond its current capacity within a short time frame. Therefore, from the participants perspective it was important to understand how the therapeutic groups had impacted on their ability to adjust and cope with the consequences of living with a CHC. From the clinician's perspective it was important to understand how they evaluated the programmes' effectiveness and what their experiences were in implementing the manuals to the group.

In summary, this study uses multiple ways to evaluate whether the treatment is effective. It uses psychometric inventories to assess quality of life and distress. It also considers group participants' experiences and responses, as well as clinicians' experiences and observations.

8.3 Measures

8.3.1 Quantitative data.

To provide evidence for evaluating the programme treatment effectiveness quantitatively, the study used brief psychometric measures to examine quality of life and distress. The measures are already used by the HCPS in clinical practice, and Massey University, in larger health research projects. They were selected based on the

research questions which arose from the literature review and to provide outcome data which would be suitable for programme evaluation purposes. Three psychometric forms were used in this study, namely, the Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983), the Outcome Rating Scale (ORS) (Miller, Duncan, Brown, Sparks, & Claud (2003), and the Short-Form Health Survey (SF-12) (Ware, Kosinski, & Keller, 1996).

The measures were collected by two clinical psychologists facilitating the group prior to beginning the group, at the end of the therapy sessions and at the completion of the group treatment. Research shows brief measures are reliable, valid and practical for initial assessment and appraisal of treatment efficacy in a clinical setting (Campbell & Hemsley, 2009). Both the pilot and the main well-being group manuals used the same psychometric tests and administration protocols.

The HADS assessed quality of life and symptom severity of anxiety and depression in clients. The HADS psychometric properties include a Cronbach's coefficient alpha of 0.60 for reliability, and 0.70 to 0.90 for sensitivity and specificity in measuring depression and anxiety in general or non-psychiatric populations (Bjelland, Dahl, Haug, & Neckelmann, 2002).

The ORS assessed treatment outcomes and efficacy following psychological intervention. According to Miller et al. (2003) it has demonstrated good test-retest and internal consistency reliability (0.93). The measure displayed good sensitivity to change, and was able to discriminate between client and non-client samples.

The final measure used was the SF-12 which measures general physical health and mental health status. SF-12 has proved useful comparing the relative burden of

diseases, and for appraising treatment efficacy. The SF-12 has been used to describe health status in a number of conditions and to measure the effectiveness of a specific intervention. Ware et al. (1996) report a Cronbach's coefficient alpha of 0.70 for reliability, and 0.72 to 0.87 for internal consistency. Also, it has sufficient evidence for test-retest reliability with regard to the physical and mental health subscales.

Due to the lower than expected number of participants, it was not possible to analyse the results using inferential testing. Other types of analysis were considered such as comparing individual scores to group norms and standardised cut offs. However in consultation with supervisors it was decided to report results consistent with their use in a naturalistic clinical setting. This was for a number of reasons. Firstly, several members had received therapy for up to one year prior to the groups. Existing research indicates greatest outcome change from engaging in therapy is likely to occur in the first few sessions (Miller et al., 2003). Also, data from the clinic pertaining to clients in prior therapy was not available to the researcher. Only data collected in the group sessions was able to be used. Lastly, consideration was given to how a busy clinic was likely to monitor and interpret psychometric data in future groups. In this case, clinicians would be concerned primarily with client safety, and would consider group members' therapy progress based on individual results and level of clinical severity.

The psychometric data from all participants in both groups, including those who did not choose to participate in interviews, were used in the analysis.

8.3.2 Qualitative data.

Psychometric inventories are limited as valuable data may fall outside of the constructs that the psychometric inventories measure. Hence, this study also used a

qualitative semi-structured interview which aimed to examine the experiences of the participants. The participants were asked broad open-ended questions, which aimed to determine which aspects of the manualised therapeutic group they recalled as being strengths or weaknesses of the programme, and whether from their perspective they benefited from attending. The interviews took place within two months of participants completing their group sessions. The clinicians were also interviewed to garner their experiences in facilitating the groups and implementing the manuals. This was in order to enhance the findings from this study and to make recommendations for future groups to the HCPS. Analysis of all of the interviews used a thematic analysis approach.

Thematic analysis is extensively used within qualitative psychological research because it is effective in identifying patterned meaning across a dataset. Consequently, it has been used across the social, behavioural, and other applied sciences. Braun and Clarke (2006) suggest it is flexible and has numerous advantages including its ease of use and ability to be used with diverse theoretical and epistemological approaches. Given that the group sessions have treatment components devised from multiple theoretical backgrounds, thematic analysis was considered appropriate as it can traverse varied theoretical and epistemological approaches. Further, complex detailed and rich data is able to be generated from its use.

8.4 Participants

The sample for this study was drawn from adults referred to the HCPS in Palmerston North. There were no individuals who identified as Pacific Island or Maori. The clinicians who facilitated the groups managed the recruitment process for selection and participation in the manualised group treatment programme outside of the

researchers input. Some clients were referred directly to the groups by external health professionals. However, in general recruitment for the groups was problematic. One reason was that the HCPS covers a large geographical region and gaining sufficient new group referrals at the same time in the same location was a significant issue. Hence, the HCPS offered existing clients the opportunity to join the groups. Thus, some participants were in one to one therapy for up to a year prior to joining the groups. The clinicians selected participants from clients already in the HCPS, whom they perceived as potentially benefiting from attending the group.

8.4.1 Client participants.

To be eligible for the HCPS, clients must have a medically diagnosed CHC such as diabetes, asthma, cardiovascular condition or COPD. Some of the group participants had more than one health condition.

The HCPS sent a letter to the participants briefly outlining details of the group (Appendix B). A total of nine individuals comprising four male and five female participants attended either one of the two the groups. Of these participants, four attended the pilot group and five attended the main well-being group. All participants lived within the MidCentral District Health Board area and were New Zealand citizens. Also, all participants were given pseudonyms chosen by the researcher.

From the pilot group, three individuals attended a semi-structured interview. One further participant consented to being interviewed, but was excluded from the study due to a severe decline in physical health. The pilot group participants' ages ranged from 57 to 74 years old with the average being 64 years of age. Most participants were

sickness beneficiaries with only one person employed at the time the group was held.

The average age of the semi-structured interview participants was 62 years old.

The main well-being group had five members and was run from October to November 2012. The ages of the main well-being group ranged from 50 to 63 years old, with the average age being 58 years old. Two were male and three were female. Two were employed and three members were beneficiaries. From the main well-being group, three individuals attended semi-structured interviews with the average of 62 years old. Table 2 below provides details of CHCs affecting participants from both the pilot group and main well-being group.

Table 2

Pilot and Main Well-being Group Participants

Name	Age	Chronic Health Condition
Ann	57	COPD, Cardiovascular
Fran	74	Asthma
Ralph	61	Type 2 Diabetes
Tom	60	Type 2 Diabetes
Mary	62	Asthma, Cardiovascular
Jan	65	Type 2 Diabetes, Cardiovascular

The participants' responses and data from both groups were combined to preserve anonymity.

8.4.2 Client inclusion and exclusion criteria.

The inclusion and exclusion criteria for both groups in the study were the same. As this research study was embedded within the HCPS, participants were clients who had already met referral requirements for being accepted into the Service. There were additional inclusion and exclusion criteria beyond the referral criteria.

To be included, participants had to have a diagnosis of a CHC and had to have been informed of their diagnosis. Also, participants had to be over 18 years of age. Finally, the participants needed to have attended two or more sessions and have completed outcome measures on at least two occasions.

Participants who were terminally ill, had a cognitive impairment, or had a physical impairment sufficient to cause physical discomfort during the group sessions were excluded from the study.

Responses from six participants both from the pilot and main well-being group were combined for analysis. This was to preserve anonymity due to low number of members in each group and high interview response rate. Also, differences in content between manuals were deemed to be minor according to the researcher, participating clinicians and first thesis supervisor. It is assumed that manual differences would not have significantly impacted on participant responses.

8.4.2.1 Dropout Rates.

Both groups did not have any dropouts and both groups had high attendance rates. In fact only one participant from either group missed two sessions and one other participant from both groups missed one session. However, two individuals who

consented to join the main well-being group withdrew prior to the group beginning due to surgical treatment which made them physically unable to attend.

8.4.3 Clinician participants.

Clinicians working for the HCPS were interviewed to obtain their perspective on the experience of facilitating the therapeutic groups. Details concerning the clinicians' demographic details, clinical backgrounds and experience are not provided to preserve anonymity given the relatively small number of clinicians who work in the HCPS.

Clinicians were contacted by the researcher to ask questions about the study and, if agreeable, to arrange an interview. The inclusion criteria for clinicians were that they had to be involved in facilitating either the pilot or main well-being group. No clinicians were excluded. Three clinicians agreed to be interviewed and were given pseudonyms to maintain anonymity.

8.5 Ethical Issues

The researcher was attuned to safety throughout the execution and compilation of the research project. At all stages, participant confidentiality and security of the data were prioritized. The Central Health and Disabilities Ethics Committee granted the study ethics approval with two minor emendations (CEN-10-07031/AM02). Firstly the information letter was revised and rewritten in less formal language. Secondly, the participants were given an option of informing their General Practitioner. None of the participants requested the option of informing their General Practitioner. Issues regarding confidentiality and anonymity were discussed with participants prior to the interview. To preserve participant anonymity and confidentiality, ethnicity and country

of origin were excluded. In case a participant became stressed, support and assessment measures were available for re-referral to the Psychology Clinic. No one exercised this option.

8.6 Data Collection

An interview schedule (Appendix D) was developed. It was amended in consultation with the researcher's supervisor. Broad topics for discussion were guided by the literature and aimed to explore participants' experiences from attending the therapeutic group.

Initially, all the participants were sent an invitation letter to consider further information and to join an interview as part of the study (Appendix E). Two participants from the main well-being group did not respond to the invitation to interview. Those who responded received an information sheet (Appendix F) and were telephoned and invited for an interview. A period of at least one week was given to allow the participants to contemplate their participation before they were telephoned to arrange an interview time. There were no refusals from the telephone response to participate in the interview. Everyone who was approached completed the interview and signed all consent forms. All participants received interview question sheets prior to the interview (Appendix D). A further copy of the original question sheet was also presented to them on the day of the interview prior to recording the interview.

Six individual, semi-structured interviews were conducted with participants from both groups. All of the interviews lasted between 40 and 80 minutes, with an average of 60 minutes. The participants were invited to choose where they were to be

interviewed and all selected a home-based interview except for one participant who requested to be interviewed at the Massey University Psychology Clinic.

Before the interview with the group participants commenced, each participant signed a consent form (Appendix G) and a release of transcript form (Appendix H). The researcher taped the sessions using a digital voice recorder. While questions had been provided, participants were encouraged to talk freely and discuss what was of importance to them. Prompts of “How did that feel?” and “What did that mean to you?” were used to encourage participants to expound on their health experiences. The participants were thanked on completion of the interviews and each paid a koha of \$20 for participating.

Once the interview was completed, the researcher wrote personal thoughts and impressions from the interview in a field diary. The interviews were transcribed verbatim by the researcher, and insights that came to mind during the transcription process were duly noted.

Each participant received a copy of their transcript within four weeks of their interview. They were able to edit and add to their stories. One participant removed a minor detail from the transcript pertaining to their child. One participant returned their transcript with a letter containing additional information.

The clinicians were asked to participate in the study via telephone and gave verbal consent to join the study. They were sent a copy of the clinician questions (Appendix I) and given a further copy on the day. Two of the clinicians were interviewed at the Massey University Psychology Clinic with the third clinician electing to have a phone interview. Three semi-structured interviews were conducted with the

clinicians. All of the interviews lasted between 40 and 70 minutes, with an average time of 60 minutes. The researcher taped the sessions using a digital voice recorder. The clinicians were likewise encouraged to talk freely and the same prompts were used as those for the client participants. The clinicians were thanked on completion of the interviews and each given a \$20 koha for participating. The clinicians were sent copies of the transcripts and invited to amend the scripts. However, no-one took this option.

8.7 Thematic Analysis

Psychological science has traditionally taken a positivist empirical approach, focusing on producing knowledge through observable and measurable evidence. However, this neglected crucial aspects of social experiences. The view that other principles could depict knowledge of social life led to the development of different qualitative methods for conducting social research (Tuffin, 2005). One such method is thematic analysis.

The evaluation of the manuals required a method that would allow the participants and clinicians to tell their stories. Interview schedules were used as a guide, but participants were able to discuss what was relevant for them. Patton (1987) stated data and analysis for programme evaluation should consider how the programme affected participants. Thus, people should be interviewed and any observed outcomes and impacts of the programme, such as strengths and weaknesses, should be reported. Given that the aim of the research project was to evaluate the manuals, it was important to understand participants' experiences, in order to assess from their viewpoint, the treatment acceptability, benefits and any potential harm. Further, a naturalistic inquiry

using a qualitative approach was important as programmes may change over time if participants or conditions change (Patton, 1987).

Thematic analysis is widely used in health research across disciplines including nursing and psychology, and in health conditions such as heart disease (Fini & Cruz, 2009), diabetes (Wilkinson, Whitehead, & Ritchie, 2014), asthma (Hennessy-Harstad, 2013), and COPD (Bentsen, Langeland, & Holm, 2012). Further, Joffe (2012) points out that thematic analysis is a valid research method for establishing models into human experience, especially human thought, feelings, behaviours and subjective experience. Braun and Clarke (2006) state thematic analysis does this by accessing the data contained in the participants' language from sources such as text from transcribed semi-structured interviews, and other text such as diaries and letters. Thematic analysis then maps out a range of ideas and concepts that participants may hold, and summarises data into the thematic categories. These categories may be affective, cognitive, or symbolic dimensions. The purpose of the categories is to help understand research topics, such as, what can influence people's decisions and whether or not to avail oneself of health services (Joffe, 2012).

Brown and Locke (2008) suggest that thematic analysis is particularly useful in the area of applied and practical research settings as it enables the combination of mixed methods research such as used in this project. A further reason included the fact that previous research conducted within the Massey University Psychology Clinic also used thematic analysis (Croy, 2010; Nixon, 2013). Therefore, it was important to use a comparable method of analysis. Health is at the core of this study. The value to be gained from results of this research project is that it can help influence how health care

delivery is framed and delivered in the HCPS, as well as furthering the knowledge of the value of manualised group treatment programmes in working with long-term CHCs.

8.7.1 Critique of thematic analysis methodology.

Compared to other forms of qualitative research, thematic analysis has been criticized for requiring less understanding of the complexities of more theoretical qualitative techniques (Howitt & Cramer, 2008). A further criticism of thematic analysis is that the method has not been thoroughly elucidated. However, Braun and Clarke (2006), and Leininger (1994) both give explicit and clear examples for using thematic analysis. Moreover, because thematic analysis is flexible and not tied to a detailed theoretical stance (Braun & Clarke, 2006), thematic analysis enables a researcher to explore phenomena without confining enquiry to predefined theoretical parameters.

Despite the available examples for using thematic analysis, undertaking analysis without a theoretical stance can be problematic. In this study, because there was no predetermined theoretic stance, developing a coherent and sufficiently in-depth analysis required the development of a consistent reasonable and logical thought process to be followed by the researcher.

8.7.2 Other forms of qualitative research considered for the project.

Interpretive Phenomenological Analysis (IPA) and Grounded Theory (GT) were also considered for this research project. IPA examines experiences and the meanings that participants hold for them. IPA attempts to tie underlying cognition and thinking to verbal reports by studying lived experiences (Smith, 2004). It systematically explores life transforming actions or decisions, at a time where the participant is reflective or re-

interpreting their lives. Hence, IPA is valuable for examining the process that occurs in a subjective experience and how participants make sense of these in their lives (Lyons & Coyle, 2007).

GT according to Cooney (2011) is a systematic methodology which aims to inductively discover theory through the analysis of data. From the analysis, a theory is generated and this is presumed to explain the data. Thus, it generates inferences for other contexts, and these contexts provide potential examinations of the theory. Usually, qualitative studies attempt to provide an account representative of participants' experiences. However, GT aims to ask how accurately the theory explains rather than describes a situation (Cooney, 2011).

However, subjective experience was not the focus of this project, thus IPA was deemed inappropriate. Also the generation of a theory to explain participants' data was not the research emphasis as occurs with GT. In this study, the participants' thoughts and beliefs about the group in general were of particular interest. It was important to examine how the participants applied their thoughts to their health care and what action took place as a result of their involvement in the group interventions.

8.7.3 Analytic process.

Thematic analysis was performed according to the outline provided by Braun and Clarke (2006). This study used analysed transcribed interviews and an unsolicited letter to the researcher from a participant regarding the group.

Braun and Clarke (2006) outline that the process of coding in six phases in order to develop meaningful patterns. These steps include: the researcher familiarising themselves with the data, generating initial codes, searching for themes among codes,

reviewing themes, defining and naming themes, and producing the final report (the steps and how they were applied to the research is explained further in the following sections). Themes were identified as patterns across data sets and these patterns were categorised for analysis. These identified themes are important to the description of a phenomenon. Thematic analysis was applied in this research from an inductive, semantic and realist approach. Thus, identified themes were connected to the data in an explicit rather than an interpretive manner. Additionally, participants' experiences and motivations are theorised as being reflected and related to their language (Braun & Clarke, 2006). The following sections explain how these steps were followed.

8.7.3.1 Becoming familiar with the data.

The interviews were conducted by the researcher. A field diary was kept to record impressions of the participants and the interview, and to record further details or information revealed by the participants after recording had finished. The recordings were transcribed verbatim by the researcher in order to familiarise and immerse herself in the participants' accounts. The interview transcripts were thoroughly reviewed once completed. Before the coding process began, each transcript was repeatedly read to check the transcription accuracy and to define the central features that each participant had communicated. Data software was not used in this research given the small number of participants, and to allow the researcher to become more familiar with the data.

8.7.3.2 Generating initial codes.

The initial coding was performed once all the interviews for each group and the clinicians had been transcribed. Gibbs (2007) highlights the importance of coding in

order to create an analysis of data which is theoretical, methodical and critical. It was important to avoid describing the data and to move from a descriptive to an analytical systematic comparison. Hence, for the purpose of this study, the initial coding was from data that exemplified similar examples which helped to establish a framework for the thematic ideas. Gibbs (2007) stated this type of analysis allowed for analytical questioning and identified relationships between codes. Further, Gibbs (2007) suggested that writing memos was a means to record the process of analytic thinking, and to identify the thinking that lay behind the work, to ensure codes were implemented in a systematic and consistent way (Gibbs, 2007). The meaning of each code was written in the margin of the transcript. This process enabled the researcher to simultaneously identify recurring key phrases and patterns of statements. Codes were developed from literature, interview schedule topics and hunches. The participants' and clinicians' overtly stated acts, thoughts, behaviours, experiences, perceptions and insights were also coded.

Initial codes used in this research were topics related to change processes and factors that would impact on change. Thus dialogue containing comments about support, family, knowing, interactions with others, session content, communication, contrasting statements, health, improvement, illness, action (what happened), behaviours, and self-reflection were identified in the search. This included how participants regarded the programmes strengths and weaknesses, what therapeutic components helped and impacted on participants' lives, treatment acceptability and whether additional therapeutic factors were present. It was also important to ascertain if any possible unhelpful factors were present.

8.7.3.3 Searching for themes.

The codes and adjoining statements were placed into categories according to the recurrence of major themes and sub-themes. The Primary Supervisor read the transcripts and checked the codes produced by the researcher. Themes and sub-themes were also discussed with the Second Supervisor. Gibbs (2007) stated the importance of “question what is going on, what people are doing and saying, what these actions and statements take for granted, how do structure, context serve to support, maintain, impede or change these actions and statements” (p. 42). In qualitative research responses are aggregated across group members. However, with smaller groups it is possible to have more diverse responses and a general lack of agreement will possibly occur.

Care was taken to ensure themes which identified the richness of the group experience were coded. Thus, initially as well as themes common to three or more participants, idiosyncratic experiences were also identified.

8.7.3.4 Reviewing themes.

During analysis, the themes were reviewed and refined. The themes and coded data extracts were considered for their coherency and whether the patterns were considered valid and reflective of the overall data. A thematic map of the analysis (Appendix J) was created and the themes were considered to see whether they were consistent with the whole data set. Validity was discussed with both supervisors.

8.7.3.5 Defining and naming themes.

On-going analysis refined the details of each theme. Theme names changed and were reconsidered to reflect the participants' overall story. Each theme was analysed to ensure that it gave clear definitions and thematic names.

Once this process was completed an additional explicit search and analysis was conducted to find if there were individual themes based on the biopsychosocial framework in an attempt to link qualitative data to the manual's content.

8.7.3.6 Producing the report.

The findings and selected extracts are reported in the results section of this thesis.

8.7.4 Data analysis.

The manuals which were described in previous chapters used the biopsychosocial model as a framework. On completion of the six steps for thematic analysis, and considering the emergent themes, it was decided to make an overt search of the data for themes which connected to aspects of therapy covered by the biopsychosocial model, quality of life and distress. Further, it was intended to incorporate this data with the conventionally analysed themes. The aim was to aid evaluation and compare participants' analysed experiences from the thematic analysis, with changes they mentioned in functioning, action, or behaviour modification, as a result of attending the groups.

8.8 Reflexivity

While it is necessary for the researcher in qualitative research to identify their subjective position it is impossible to identify every aspect of personal influence. Van Manen (1990) highlights researching lived experiences requires orientation to the phenomenon from a particular vantage point. The researcher interacts with the participants and tries to understand from the participants' point of view their experience. At the same time the researcher is drawn into the study through their own experiences and involved interpretations of phenomena. As I immersed myself in this research project, I recognised several influences which have enriched my perspective. As I interviewed participants I could not help but consider my personal experiences of CHC within my whānau (family and extended family). Several members of my family have passed away from a CHC. My maternal grandfather died in his sleep from a heart attack aged 56 when I was barely a month old. However, stories about him and memories regaled to me were ever present in the large whānau in which I grew up. My paternal grandmother with whom I was very close, having spent a large part of my childhood in her home, died when I was 21 years old. She received a small scratch on her leg. Her type 2 diabetes CHC meant the scratch never healed, ulcerated, and eventually complications arose leading to her death. Type 2 diabetes complications were also a condition that my father suffered from, along with a decade of surgery and treatment for cardiovascular disease. I watched as a strong, self-reliant, physically active man lost his independence because of glaucoma, fatigue and increased reliance on others to provide for his care. During the study the impact of his death further impacted on me. I vividly

recall looking at Ministry of Health statistical data and realising my father was one of the mortality statistics I was studying and is included in the statistics in my project.

Other factors besides encounters with CHC have impacted my life. Smith and Eatough (2006) speak of the researcher documenting their own sense making and the importance of a researcher revealing a careful and justified rationalisation of their stance in an investigation. Prior to the research project, I had positive experiences running groups and felt my experiences could help the programme. I ran approximately 15 public parenting groups over six weeks each, for a period of three years. I enjoyed meeting new people and seeing participants grow in confidence, develop new skills and form new friendships. I saw the value of well-run groups impacting positively on lives. When I heard of the possibility of developing a manual and conducting group research, I became interested in the project because of the groups I had run.

I had to develop a critical approach to the study. During the interviews with participants, I realised their responses were to a manual that I had a vested interest in. It is possible this may have limited the type and quality of data that was collected. Also, during my interviews with clinicians, I recognised dual roles were present. My Clinical Psychology training exposed me to completing practicums and attendance at regular clinical training in the psychology clinic where participants worked. Thus, conducting research and being a student attending the Service may have had an impact on the collection and the analysis of the qualitative data. It is not possible to work alongside, collaborate on manual material, interview clinicians and then analyse and report data to the same clinicians without being mindful of personal and professional relationships.

However, several factors also aided in maintaining and developing critical

thinking. Firstly, I maintained a field diary that recorded my own narrative such as impressions and self-reflections while conducting this research project. I believe I had greater insight because I was immersed so deeply in the project in comparison to someone who may not have been as familiar. Secondly, during the interviews, an empathetic approach was required, with minimal leading questions. Two prompts of “what was it like?” and “what did it mean for you?” and reflective statements repeated back to the participants formed an integral part of the interviews. Thirdly, adherence to the thematic analysis technique during the research process and following a stepwise process during the analysis, aided in organising and integrating results. Lastly, regular contact and discussions with the project supervisors and health professionals familiar with CHC and thematic analysis were also very beneficial. Comments given in supervision were written into a diary and reflected on both during and after supervision.

RESULTS

CHAPTER 9 CLINICIAN FINDINGS

9.1 Results Outline

The research results from both clinicians and group participants are presented in the following chapters. Firstly, the clinician results are depicted. This is because the clinicians' involvement spanned the development of the manuals, facilitating the groups and evaluating the client responses and effectiveness of the therapy. In the next chapter the participants' psychometric results are described. The following chapter presents the participants' qualitative results based on their semi-structured interviews.

9.2 Clinicians Results

This chapter presents the themes that arose from a thematic analysis of interviews with three clinical psychologists working in the HCPS. The clinicians facilitated the groups and worked with individual clients, couples, and families. One clinician had previously facilitated the Living a Healthy Life with Chronic Conditions (Lorig et al., 2006) group. For the purpose of maintaining anonymity, pseudonyms were assigned to the clinicians. The themes included *Becoming A Group Facilitator, Preparing For The Session, Meeting The Participants' Needs, Managing The Group, And Evaluating The Session*.

Becoming a Group Facilitator

Learning New Skills

Preparing for the Session

Meeting the Participants' Individual Needs

*The Therapeutic Alliance in a Group Setting***Managing the Group***Getting People Involved**Reining People In**Governing the Sessions***Evaluating the Session****9.3 Becoming a Group Facilitator**

The first theme identified in the study focused on professional development and growing into the role of being a group facilitator. Hopkins and Irvine (2012) identified one of the fundamental qualities of health workers was the need to be flexible and holistic when considering client health needs, in order to improve their well-being. It is unclear from their research as to what extent therapist characteristics, combined with training and experience, enable a clinician to become flexible and manage change such as from individual to group therapy. The clinicians in this study perceived that their experiences with the groups changed their thinking about groups and facilitated their professional growth as clinicians. One of the clinicians, Claire, experienced an increased recognition of how she had grown professionally.

*I think there is a lot to be said for groups. It has increased my awareness of how much there is, how much potential therapeutically there is in a group environment. And that has been really beneficial for me individually as a clinician and for the Service. To recognise that and to have that in my thinking for where we go in the future... **Claire***

When Claire reflected on the group, she thought only in terms of her work role or herself as a clinician. As she implemented the therapy, her perception of herself as a

clinician changed and grew to encompass her new ability in facilitating groups, but not necessarily her perception of herself as a person. Claire believed that her experience as a clinician in the group had been beneficial for her clinical skills. Through her experience, she came to a realisation that clients could receive therapy from the groups in ways she had not explored. Furthermore, her ability to practice effectively in a number of areas had increased in scope. She had not thought about these opportunities prior to running the group. She was surprised it had helped her, but exactly how it had helped, was not to the forefront of her thinking. Deeper insight was outside the scope of her reflections as she pondered how running the group had increased her ability to be more flexible with her clients.

Diane's experience of flexibility and growth, both personally and professionally, was different. She realised the small group size meant she was able to transition from running individual one-on-one sessions to a group, more easily than she thought she would.

And because it was quite a small group it was probably a nice way to start out with it. Because it wasn't quite a lot of managing challenging members of the group and things like that that we had to do. They were a really lovely group and they interacted well. Everyone, there wasn't really anyone, who was too overbearing or anything like that. Or at the other end of the spectrum, who didn't participate at all. Diane

The clinicians were asked whether they thought the groups were cohesive. In her understanding of cohesiveness, Diane considered the relationships between the participants. However group cohesiveness also encompasses the group's ability to work together in a meaningful manner to bring about therapeutic change. Because the people in the group were being cordial to each other, she realised running the programme was more manageable than she expected. Diane assumed she would grow as a clinician

because she would encounter difficulties with either conflictive or unengaged participants, or she would need to manage a diverse range of unpredictable interactions. Diane recognised her inexperience in group work and had thought the task ahead of her would challenge her skills. However, the reality of the small group meant Diane experienced relief. Her sense of relief was based on her perception that the participants were getting on well with each other. Diane's growth as a clinician meant she did not have to be as flexible as she had anticipated and she could indeed manage a group. What Diane did not recognize though was that despite her participants relating well to each other and to her, it did not necessarily mean they were cohesive and working well together as a group.

Rose reflected on her clinical training and how it focused on individualised treatment programmes tailored for each client.

*I think in my training there was a lot of focus on individual therapy and there is this idea of being very client centered and developing individualised treatment plans. It is all about not using one model, and targeting somebody's need. Which then kind of conflicts with the idea of a group where you have a standardised programme or a standardised range of topics. So I get there is a little bit of difference in what we are taught around that. But on the other hand, you are just really mindful of just how real life experience is. And that it is really helpful to have people with other people that have been experiencing the same thing. And the value that it provides because you just cannot get that in individual therapy. **Rose***

As she thought about becoming a therapeutic group facilitator, Rose experienced a dilemma. She thought about her training and its focus on individual therapy being effective in comparison to a standardised group programme. Rose had to change her thinking as she saw participants experiencing beneficial outcomes from being in a group, which contradicted her training. Rose was taught individual therapy was the gold

standard of treatment. As she reflected on this, Rose integrated and expanded her clinical knowledge in her transition to facilitating a therapeutic group. In order to accommodate her training and the reality of her clinical experience, Rose became attentive and aware of the participants' progress. She paid attention to participants gaining support from recognising other group members who also had similar problems. She recognised the value of being open to learning new perspectives of what worked for her clients based on actual clinical experience. In order to do this, Rose had to put aside her preconceived ideas concerning the benefits of individual versus the therapeutic group. Rose saw the value of a therapeutic group was its ability to give participants similar shared experiences and saw the group gave participants a valid useful treatment option. Rose was unaware of the importance of the development of socialising which occurs in groups and is one of Yalom and Leszcz (2005) key therapeutic factors.

The clinicians involved in facilitating the therapeutic group commented on their growth as clinicians. They reported that they became flexible and their perceptions regarding implementing therapy changed. Scant literature considers clinicians' growth and changes from being a provider of individual therapy to a facilitator of therapeutic groups. Johansson, Borell, and Jonsson (2014) in their study with occupational therapists implementing a group, described how the therapists' experiences changed over the course of the group. At the beginning of the intervention, therapists commented that their role was uni-directional, expert-driven and involved them imparting knowledge to the group. This changed over the group sessions with therapists moving to engage and activate the participants to share their experiences. Yalom and Leszcz (2005) also suggested leadership style improves and changes with experience of running

groups, but do not define the factors necessary for this change or improvement to occur. In general, research such as Burlingame et al. (2001) considers clinicians facilitation of groups in terms of a therapist modeling participant interactions and explicitly setting group norms which reinforce interactional patterns among the group. Research has also focused on therapist's characteristics which include positive relationship-building attitudes and behaviours such as empathy and genuineness in their interaction with the members (Burlingame et al., 2001).

9.3.1 Learning new skills.

All of the clinicians had previously worked therapeutically with educational groups, couples or families. However, none of the clinicians had run a therapeutic group. When asked about running a therapeutic group, all the clinicians had different perceptions. Diane compared the group to the enjoyment she experienced doing couple and family therapy.

I have done kind of workshop groups so, but not in a therapeutic sense...It was good. To be honest it was kind of um. I enjoyed it. I really enjoyed doing the group. And I kind of knew that I would because I enjoy doing family and couples work...So it was probably quite a nice experience to come into... **Diane**

As Diane reflected on her experience, she did not differentiate the group from other situations she had facilitated. While she had anticipated that she would enjoy the group, it is unclear from Diane what specific aspects she enjoyed. Her overall awareness and insight into why she enjoyed the experience is general rather than specific. This differed from Claire's account. Claire reflected on the disparity between the groups, particularly in relation to not knowing how people would interact with each other.

Whereas from the group, you are not going to know what the dynamic is in the group, what it is going to be until you get into running the sessions. So there was kind of a bit more unknown in terms of how people would interact. Whereas in a family situation you have already or pretty quickly in assessment get an idea of how people are interacting or not. So the group it was a bit different...well possibly because it was a new situation as well perhaps was more waiting to see the dynamics as well. so there may have been more sense of uncertainty from me with the family situations in which I am more familiar...

Claire

Claire experienced uncertainty in not being able to predict and be certain of the participants' reactions. She recognised that the group was different to her previous experiences and this was novel for her. She reflected on how it made her feel. Not being able to predict interactions appeared to leave Claire feeling less confident in a session. It is not clear what impact this may have had on participants or if they were also waiting to see how the group dynamics developed. It is also not clear whether using the new treatment manual for the first time contributed to Claire's uncertainty.

The clinicians were aware that their experiences were fundamentally different when they were facilitating the therapeutic groups, in comparison to other settings where they had managed multiple participants, such as, in family therapy. While they spoke of how they enjoyed facilitating the groups, it was not evident what aspects of their role they did enjoy.

Summarising the theme of becoming a group facilitator and sub-theme of learning new skills, the clinicians' experiences of professional growth saw an increase in their ability to be more flexible in their thinking when considering the benefit of the therapeutic groups. Furthermore, they were able to recognise that the changes they experienced were for the benefits of their clients and that their clients' needs would be met. This required the clinicians to adjust their perspectives beyond their previous

clinical training and therapeutic experiences. The clinicians actively sought to fit and integrate the concepts of the therapeutic group into their work roles in a positive manner. This led to a reflection that they had to diversify their roles and skills and attempt to apply these skills. By being flexible and being able to strike a balance between the needs of the participants, managing a group, and following the procedures of the manual, the clinicians experienced professional growth and learned new skills as group facilitators. Research is scarce on novice facilitators' experiences but Johansson et al. (2014) found that their participants needed to actively change their roles when they became facilitators. In particular, they had to move from being an expert to a more complimentary role in the group to allow the group processes to evolve.

9.4 Preparing for the Session

When the clinicians were asked about their experiences of implementing the manual, it was evident that clinicians had to mentally prepare and think about how to implement the manual during the sessions. Diane prepared for the group by reading the manual and making notes and a short summary.

What I ended up doing was I would read through the session for that day and I would end up creating for myself a short summary that was sitting there in the session. And I would kind of glance over it and think yep, that is what we have got next. And it triggers your memory of the dialogue. I think that was useful...As I was reading the manual I was doing a lot of thinking about how I was doing my work that I have done so far with clients that I have. And how did the clients find this. How would my high functioning clients find it, versus my low functioning clients find it. So I guess I was constantly evaluating that and I guess I was imagining myself with the dialogue, how this would come across to the client **Diane**

Diane imagined and reflected on how participants were going to respond. She prepared for the group in the same manner she would for her individual work and

considered her participants based on her previous work. This was to be expected as Diane did not have previous group experience. But, Diane assumed the group would respond to the therapeutic elements in the same manner as her individual clients.

Diane also prepared for the sessions ahead of time with her co-facilitator, Claire. They discussed and collaborated on what was important for the participant's therapeutic needs, and used the manual in a way that met the needs of the participants.

*You do have to be flexible with it, you can have the best manual in the world but sometimes you know you are not going to be able to achieve everything set out and that is just realistic and I think it probably wouldn't be in the client's best interest to nearly always stick exactly to a manual anyway. So I think Claire and I would kind of go through it in preparation for the group. What there was in that particular session and then decide these were certain things we would leave out and maybe given time these were the things we felt we did need to cover. So we did use it reasonably flexibly. **Diane***

Diane reflected on the need to prioritise the material for the session and to remain flexible. Furthermore, she considered that the manual should be used as a guide and not necessarily adhered to at all costs. She perceived that preparation meant developing a tailored therapy plan based on the manual rather than following the manual in a stepwise manner. Diane considered the eclectic nature of the therapies and the coverage of the manual. She considered the relevance of aspects of the dialogue, exercises and therapeutic components, before deciding on what to implement. Moreover, in her clinical practice she acknowledged using a specific therapy modality more often than other therapies with her clients.

Another clinician, Rose, prepared for the sessions by looking over the material before the group.

I don't think I did. I am just trying to thinking back now cause the kind of idea that we had was that the manual was given to me to look at and it

was pretty much a this is what we are doing... I think the objectives quite clearly captured what was supposed to be happening in the session. But again that kind of aligns with what the sessions were. Rose

Rose reflected on how she did not have significant preparation as she implemented the manual. Rose thought the approach had to fit everyone's needs but it was restricted to a set approach. Rose used the layout of the session and the outlined session objectives to plan the therapy for that session. Rose was able to follow the instructions easily and be more compliant with the therapeutic content because both the objectives and the therapeutic element were associated to each other and made sense to her.

Wardale (2013) commented on facilitators' thoroughness in preparation for groups entailed adequate briefing of both the material and ensuring they understood the participant group. The process of preparing for the session in this study highlighted the difficulty clinicians had to maintain fidelity and adhere to the manual in some situations. Consequently, they used their clinical judgment to meet the perceived client needs. This did not present a difficulty in the minds of the clinicians as client needs remained paramount and at the forefront of their session. Breitenstein et al. (2010) suggested that reduced fidelity is due to a number of reasons including lack of training in a programme, variations in clinician's competence, lack of technical support, lack of support for the intervention and other competing demands for clinician's time. This meant that it is easier for clinicians to fall back on known and well-practiced interventions rather than learn a new intervention.

9.5 Meeting the Participants' Individual Needs

Fuhriman and Burlingame (1990) identified that a positive therapeutic relationship between clients and clinicians within a group setting facilitates positive therapeutic gain for clients. Contributing factors to the therapeutic relationship include interactive behaviours, feelings and attitudes. Hendrick (2013) identifies that the life experience and skill set of a therapist are important especially in conducting both individual therapy and facilitating therapeutic groups in the field of psych-oncology and health. In addition, listening skills, interpersonal skills, experience within a medical environment and being open to new experiences, were considered essential attributes for a therapist. Furthermore, the primary therapeutic intervention should consider the potential impact it may have on the therapeutic relationship between a clinician and the client (Hendrick, 2013). Despite conducting a literature review, little research exists focusing on the clinician's perspectives of their experiences and contributions to therapeutic gain in group therapy.

In the present study, the clinicians were asked about their experiences of the groups, what the participants got out of the therapy and what the participants gained from attending the group. Significantly, clinicians considered foremost the individual participant's presenting problems when facilitating the therapeutic group. Furthermore, they sought to improve individual outcomes rather than focus on using the group process to influence participants' outcomes. It was notable that the clinicians did not consider the group environment as a significant way of providing holistic therapeutic care. Moreover, each clinician was unique in their insights into how they conceptualised

each individual's needs within the context of the therapeutic group. Diane experienced meeting individual needs in the group as trying to manage multiple demands.

So certainly there is a lot of variety in terms of the needs of the clients. And I guess that makes it challenging with running a group in some ways because I think you are trying to cater to those different needs. And create a group that is going to work for as many people as possible.

Diane

When Diane reflected about her role as a group therapist, she was aware of multiple components that occur within therapy. She recognised the diverse range of individuals and their problems and the requirement to manage or accommodate these. For Diane, the group process became a dynamic environment she had to actively build. As she implemented the manual and used interventions she was not familiar with using, Diane recognised that conducting the group was something she had to overtly work on. Also, compared to the seemingly unforced individual therapeutic process in her usual work setting, the group context meant she had to consciously attend to developing the therapeutic relationship during the therapeutic group. Diane's insight into what specific therapist therapeutic factors aided the group process was not to the fore of her thinking, and this left her feeling tested.

Rose also discussed providing for the individual needs of her clients.

It was good. A bit different in terms of thinking about trying to provide something to these people at that level of need. And that if they are only going to come into this six sessions, they need to get everything that they need to be able to move on from here, and not getting individual therapy as well. **Rose**

As she reflected on facilitating the group, Rose experienced the dilemma of trying to implement effective therapy in a perceived limited way. To be able to meet clients' needs, Rose realised that she had to consciously change her way of thinking

about how she managed her sessions. With individual therapy, Massey clinicians have greater flexibility over the number of sessions they provide to their clients. Rose was concerned that her clients would be discharged whether they were ready or not, leaving her with doubts about the efficacy of the group. Rose experienced being forced to consider the possibility of not meeting her clients' needs. It evoked in Rose concerns that clients would not receive the same outcomes as they would if they had individual therapy. Rose was used to developing a flexible therapy programme catered specifically to the explicit needs of one client. Therapy plans could be changed with an individual client. However, in a group situation, Rose was left questioning how she could meet her participants' needs if issues arose, given that the therapy elements were set.

Further, Rose had seen a number of the participants in therapy prior to the group. She believed attending the group would help her clients normalize their problems and reduce their sense of isolation. She had prior knowledge about the participants in comparison to a clinician who had not met the clients. This had an impact on how Rose thought about how the participants would respond to the therapeutic group. Based on what she knew about her clients, Rose considered the therapeutic group was not flexible enough to meet her participants' needs. This created a dilemma for her of not being able to give the best care to her participants.

The third clinician, Claire, also considered how individual client needs were met. When she reflected on her experience of running a group, Claire considered the client responses to therapy components.

I was looking at their buy in, investment or I guess engagement with the topics we were covering and the kind of work we were doing. Also how it was fitting for people who were attending, who were there for a variety

of different reasons as well, and whether they were helped. And, how relevant it was to those participants in each session. Claire

Claire's insight into the group showed she considered a number of outcome factors and evaluated the impact of therapy. She was aware of what had occurred with participants on an individual level and how they responded to therapy. Also, Claire considered whether the group was a good "fit" for the participants and their issues. Claire did not consider or evaluate the clinician's delivery of the therapy or how they, as clinicians, managed the group environment. Generally, the therapeutic relationship between herself and the participants and the participants' relationships with each other remained less defined in her thinking.

In this theme, the clinicians perceived the group setting challenged how they would meet the individual needs of their clients. Having previously worked with individual therapy, the clinicians remained attuned to the individual rather than a group approach incorporating group processes into individual participant needs. The facilitators did not receive training on group facilitation prior to the group. Research supports novice group facilitators receiving specific group therapy training, however access to such training in a naturalistic clinical environment can be limited.

Further, research from facilitators' perspectives in health research is limited. Newbold, Hardy, and Byng (2013) considered staff and participants' experiences of group therapy. However, the staff focused on how they thought participants experienced the group rather than their own perspective of the group. Similarly, Spector, Gardner, and Orrell (2011) in their dementia study, considered facilitators' interpretations of participants' experiences. But both of these studies were limited by small participant

numbers and they combined all their data from participants and staff together for analysis so it is unclear what the actual experiences of the staff were.

9.5.1 The therapeutic alliance in a group setting.

The clinicians were asked specifically about the therapeutic relationships between themselves and participants as well as participants' relationships with other participants in the group. Diane noticed her experience in building a therapeutic relationship was similar in the group to how she built relationships with clients in individual therapy.

I think there was really good rapport between the other clinician and I and the other members of the group. I think there are always some people you think you naturally build that rapport with more quickly and then there are people who are a little bit slower to warm up. I remember there was one particular member of the group who seemed in the early sessions she might be a bit difficult to engage and was a bit skeptical about whether the group would be useful kind of thing. But by the second session she was well engaged, we felt we had a rapport with her. It was a huge change in her presentation really. Yeah I think rapport was really good. Diane.

Diane reflected on the importance of the relationship she had with the other clinician. It is not clear from her account whether in her mind this rapport was critical to the rapport she built with the participants. However, when Diane reflected on the group, she saw that relationships within the setting had established good rapport. Diane thought about how it may take some time to build a relationship with individual group participants based on an individual's characteristics. In her group experience, she found it was difficult to engage one client. Diane assumed the participant's unwillingness to engage was based on the lack of a therapeutic relationship between herself and the participant in the first session. However, it is possible that other factors such as the

individual's apprehension about attending the group may have influenced the participant's engagement.

Claire thought about the clients' needs when she considered the therapeutic alliance within a group setting.

Well I think somehow it is the challenge of being a clinician. You do that always in your job... You are always looking to balance the client's needs with what you have to offer as a therapist... You know working clinically about balancing the client's needs and what we have got to offer the client for them to understand that as well. So you do that in a variety of ways as a clinician. Claire

Claire reflected on the therapeutic alliance as a balancing act. Her clinical experience meant the clinician's role centered on the client needs and was client-need driven. From her perspective, her input to the relationship was secondary to those needs. Nevertheless, the therapeutic relationship was seen as being dynamic and Claire had insight into the variety of ways she accomplished therapeutic alliance. Claire was mindful and purposeful of her implementation of this process, rather than relying on intuitive insight. But she did not overtly state what she did and how she built the therapeutic relationship. Claire did not reflect on whether this process changed in the group environment compared to individual client sessions.

Furthermore, most of the participants had seen one of the clinicians facilitating the group individually, prior to joining a group. Thus, in the interviews, clinicians such as Rose felt rapport was already established.

This is a tricky one because I had seen most of them already. I think there was already some kind of therapeutic relationship there. So the group I guess was just a bit of another setting for them and I didn't find it difficult at all. I think it was different because there were two of us there. So I did find that sometimes they would reference something that they might have told me in our sessions and kind of look at me, and then it would be our job to share that with the group, rather than tuning into

an individual thing within a group, so that was a little bit present. But apart from that I don't feel like it was any different. Rose

Rose reflected on how a therapeutic relationship with participants had already existed. Further, she thought about what occurred when participants moved from individual therapy to a group, and how the relationship was affected. Rose thought the relationship she had with participants continued but she noticed subtle changes. Rose was aware that having another clinician and other participants there changed the dynamic of the therapeutic relationship and it no longer occurred between two people only. This meant that Rose was consciously trying to include others, including the other clinician, into the therapeutic relationship. She sought to reduce the impact of prior interactions and purposefully included others into that shared experience. Rose experienced this as “doing her job” which meant actively creating a group rather than an individual therapeutic relationship. Rose self-reflects on her observed need to change the nature of the relationship so others benefited in the group. Moreover, Rose had insight into moments when she actively did this by including others into previously private interactions.

Bernard et al. (2008) highlighted that the therapeutic relationship in groups is more important than the theoretical orientation of the therapist. Wampold (2001) also reports that the therapeutic relationship could explain patient improvement rather than a treatment protocol.

In summarising the theme of meeting participants' needs and the sub-theme of the therapeutic alliance in the group, clinicians were concerned with individual outcomes rather than global group processes and stages of group development. In general, their reflections on how the group would meet participants' needs were similar

to how they viewed building rapport and meeting client needs would occur in one on one therapy. Further, clinicians were concerned about whether or not participants' needs could be fully met in the group setting to the same extent as they were in individual sessions. The clinicians' insights into the participants' experiences of building a group therapeutic relationship between each other remained less to the forefront of the clinicians' experiences. Schouten, Murray, Boshoff, Sherman, and Patterson (2011) found that the skills and abilities of the staff were challenged by the diversity of participants in their stroke rehabilitation group, especially in providing and planning the appropriate activities for the group. Bernard et al. (2008) also stated the therapist's aim is to bring individuals together who will challenge and support one another while developing and maintaining group cohesion. In this study, the clinicians' experience of therapeutic alliance and rapport building was focused on individual relationships within the group, rather than the group process specifically.

9.6 Managing the Group

The clinicians were asked about participant's relationships within the group, including conflicts and potential barriers. This was important, as research such as Butow, Beeney, Juraskova, Ussher, and Zordan (2009) identified group processes as presenting challenges for group leaders. This was also common in this study, where the clinicians discussed the processes of managing personalities, facilitating the inclusion of more reticent members, and managing participants at varying stages. Clinicians were mindful of the possibility that participants could either potentially cause conflict or dominate the group interactions. Equally, they were aware that participants could be unforthcoming. Three sub-themes were identified including getting people involved,

reining members in and providing sophisticated care for complex problems by governing the session.

9.6.1 Getting people involved.

Creating a group environment whereby all of the participants could fully participate was a key task for all the clinicians. When she thought about how this had occurred Claire was aware of the pivotal role the facilitator had.

*I think the facilitator has a really key role. And so initially particularly the relationship that the facilitator has with each person in the group is really important. And that the group tends to look to the facilitator too for the connection and the engagement. And as the sessions progress it becomes more about the group as well. But I think the relationship to the facilitator is quite key in the sense that the facilitator is someone that they can be open and honest with, and is not going to allow anything to happen in the group situation that would be unsafe or difficult. And I think they are looking to the facilitator a lot to role model what is okay to say and what is not. And when somebody does say something where they show a level of distress or anxiety or whatever, there is a sense that people are very much looking to the facilitator as to how to respond to that. Or how to deal with it in a group situation. So the facilitator does have a key role I think in fostering the group dynamic. **Claire***

As she pondered about the group, Claire's focus was on the role of the facilitator and although she may not have consciously thought about it in terms of a therapeutic group process, Claire was seeking to instill hope in the group. Installation of hope is one of Yalom and Leszcz's (2005) key therapeutic factors which occur in the initial stages of a group. It is the impartation of faith the therapy will help and enables an individual to continue group attendance so that the therapy can be effective. Claire thought about how important it was for the facilitator to build relationships with everyone in the group. Furthermore, Claire's perception was that the participants equally sought to build a relationship with the facilitator as much as the facilitator did with the participants. Whilst

participants all knew at least one clinician prior to the group, they did not necessarily know the second clinician involved in facilitating the group. Claire assumed that participants regarded the facilitators differently from other people they had just met. Specifically, those participants would be open and honest and trusting of her from the outset of the session. Claire also reflected on how participants built relationships with each other which gained importance over time. However, she did not consider how the relationship was characterised, such as if participants were open, honest, and trusting. As she reflected on the group process, Claire had appeared to be unaware of the potential positive effect social support from other participants had on each other. From Claire's perspective, the clinician remained the key mode of enabling participants to feel included.

However, the other clinicians found that the session organisation and layout were helpful in aiding participant inclusion. Sessions included individual, pair and group exercises, as well as clinician led interventions.

You know obviously there does tend to be members of the group who will offer examples spontaneously versus people you had to just say, "how did you find that" or "what was your experience of that." So we were really conscious of doing that particularly with the quieter members of the group....I think it was good because the sessions were quite interactive so we did manage to get people talking fairly early on. Diane

Diane experienced the group as being diverse with participants displaying different degrees of extroversion and willingness to speak in front of others. Having a small group with only a few participants made it easier for Diane to engage participants. As she reflected about the group, Diane was aware of her attempts to draw in more reserved participants by specifically directing questions to them, and giving them opportunities to speak. However, Diane also experienced the interactive nature of the

sessions. During this time, she saw the manual aid her in getting participants to talk.

Importantly for Diane, this occurred early on when the group started. Diane found the manual helped to make her role as facilitator easier than she expected. Rose also found the interactive nature of the manual was helpful in aiding participant inclusion.

*They did offer each other suggestions. If people would come up with you know a difficulty. Everybody would actually contribute with some suggestions about what they had done before. People would say ah I have tried this before and it has been really useful and then the other person seemed to take that on board and that was a really good way to do it. Even in just the beginning kind of second period people would offer suggestions and I think that was a really positive way they interacted with each other. And even when we stopped and did pair work when they paired up, I think people were pretty good, in terms of interacting with each other and supporting the other person. **Rose***

Rose experienced the group as being collaborative and co-operative towards each other. From her observations, Rose saw participants giving each other support and helpful advice. According to Yalom and Leszcz (2005) altruism as it occurs in groups in this manner can be very therapeutic. When she considered her experience, Rose was not aware of the need to purposefully draw people into participating or sharing with each other. Rather, she dwelled on examples of events in the group where she saw participants actively helping each other. Rose realised that the participants did this across the range of exercises including during pair exercises. Rose recognised that the pair events would have highlighted potential negative interactions and difficulty with participants getting on with each other. Rose did not reflect on how she could have impacted on the group or created an environment for the spontaneous interactions to occur outside of the structured exercises.

The clinicians' perception of the group was that the participants appeared to be engaged with each other. This, in part, was reflected in the dropout rates from the group

with no participants leaving the therapy and high weekly attendance rates. The clinicians observed participants' interactions and looked for evidence of problematic relationships. Despite knowing participants prior to the group, clinicians did not mention whether they considered or expected individual participants would experience difficulties.

Experiential research from the clinicians' perspective is lacking. Fuhrman and Burlingame (1990) discussed therapists' characteristics such as personality and empathy were crucial in group development. Clinicians in this study were aware of the impact they had on the group, but did not mention specific personal qualities, and the effect that their characteristics may have had on the group. Delucia-Waack (2009) stated that facilitators needed to focus on getting participants involved in activities while at the same time teach new skills. This presented a challenge and balancing act for facilitators. They saw that participants were able to make sense of the therapeutic content and learnt how to apply it in their lives outside of the group (Delucia-Waack, 2009).

9.6.2 Reining people in.

Equally important with group processes, such as including quiet participants, is the need to manage conflict between participants or individuals who may dominate groups. All of the clinicians were aware of situations where they recognised this could have potentially occurred. Further, they knew they actively managed people to minimise the impact on other participants.

There were a few times where I can think of when one particular person sort of dominated with some ideas that were probably not well accepted by the group. But most people had thought "oh that is kind of a bit of a strange thing to say." And everyone was sort of looking around. And I am pretty certain that the way we dealt with that was to actually just kind

*of address that. And just say “ok so what do other people think about this. It looks like everyone is looking a bit confused or whatever” and pull other people into it and that helped cut him off as well. And just kind of managed it through redirecting it. **Rose***

Rose attended to observed behaviour occurring in the group. She heard comments which she interpreted as jarring and off-topic. However, when she noticed other participants' visible reactions to what they had heard, Rose reflected that she saw this as participants not accepting what one person had stated. Rose named the behaviour that was happening, and its impact on the other participants. Rose united the group in their action of redirecting the dominating participant. Rose was able to reflect on her actions and how she dealt with the situation. This was in contrast to when she practiced with individual clients. This provided Rose with evidence of being able to develop a good therapeutic group environment. For Rose, she experienced reining in a participant as using the other members to bring someone under control and to stop them pulling the group in another direction. She used the group to establish uniformity and unity by using peer pressure to negotiate power control within the group.

As well as individual clinicians experiencing challenges while directing and managing a session, a unique dynamic experienced by the clinicians was managing a session with another clinician. Diane reflected on how both clinicians addressed a challenging participant. Diane experienced reining in, as both clinicians agreeing on a strategy to manage a client and meet their need to avoid a negative impact on the group.

*I think there was a time someone who was really quite depressed who became quite tearful. And we had to have a discussion about how we were going to manage that if his mood dropped further. Because there was concern about how that might impact on other members of the group. **Diane***

In her experience, Diane felt the behaviour reached a tipping point where it could not be ignored. She assessed the client's mood was low and was concerned it would fall further and discussed this with the co-facilitator. This was a novel experience for her. Usually, in individual therapy, difficulties with a client are discussed in supervision with another experienced clinician, or addressed directly with the client. In an individual session situation, should the case be discussed by a clinician with their supervisor, the supervisor may not necessarily know all the details, the client themselves, or what really occurred between the clinician and the client during the therapy session. In a group situation, Diane was concerned for how the participant would affect the group. Diane reflected on how she addressed this with her co-facilitator. They had a discussion which was fundamentally different from supervision. For Diane, her experience of reining in meant caring for an individual in a manner that would not affect the group's functioning, and other participants' well-being.

The clinicians commented they believed the group participants got on well with each other and reported there were not any instances of conflict in either group. However, the clinicians were aware of the potential for conflict to occur and managed potential conflict situations as they arose. Research reports patient perceptions of conflicts and actual conflicts in a group affected their ability to work effectively, and levels of conflict was predictive of participants' clinical improvement (Baker et al., 2013; Burlingame et al., 2011; Crowe & Grenyer, 2008; Piper, 1994).

9.6.3 Governing the sessions.

The clinicians were responsible for clarifying and implementing therapy goals and content. Further, they needed to establish and maintain a safe therapeutic

environment and encourage group participation. In order to achieve these elements, it was important for the clinicians to maintain authority in the group and control in the sessions. All of the clinicians experienced challenges in implementing the manual, therapy content and goals in a timely manner. The clinicians found as a group, the participants' conversations sometimes diverted from the topic or monopolised parts of the sessions. When she thought about the group, Claire discussed how excessive talking during therapy can actually prevent the client from receiving therapeutic gain.

...ok so I've got this client that comes in and all they want to do is talk and talk and I can't get any strategy in because they just want to talk... You know working clinically is about balancing the client's needs and what we have got to offer the client, and for them to understand that as well... Claire

When she reflected on the group, Claire compared her experience with what happened in one-on-one therapy. Claire recalled monopolised talking by one participant was a barrier to receiving all that a clinician could have imparted to a client. Claire saw it as necessary that the participant was aware of the valuable input a clinician had into building their therapeutic relationship. Claire's perspective on governing was to bring a balance to the session. Balancing was a multifaceted and complex process, but one where the onus is on the client to see beyond their problems and understand what can be achieved with the therapist. However, Claire did not reveal how balance is achieved, or what barriers there may be which can prevent both the participant and the clinician from achieving that balance.

Diane reflected on how she prioritised which allowed the participants to have the opportunity to talk and build rapport with each other, especially in the early stages of the sessions.

You know at times it is easy to get lost in the interaction, you lose course in terms of where you are at with the manual. But in some ways that was good. We probably let that go a wee bit more in the first couple of sessions because we were focused on the most important thing such as rapport building you know people feeling like they can be open and honest. Diane

When Diane thought about the group, she recalled periods when the group discussions continued to the point where she lost her place in the manual. Diane realised the conversation was deep, meaningful and served a distinct purpose for the participants. The manual has time guidelines so all of the content can be implemented. In her experience of managing the group, Diane was flexible and allowed the group to develop outside of slavishly following the manual. Diane saw that the clients developing and initiating their conversations with each other was a good thing for them to do. In Diane's experience of governing the sessions, she decided to allow participants some room so they could initiate and develop their own conversations beyond the realms of the manual. This would of course vary from group to group, depending on the experience of the clinician in using the manual, and the mix of participants and their associated needs.

Another clinician who also recognised the benefits of participant initiated and led conversation was Rose. However, Rose also reflected on how she brought the participants back into line with the session plan.

You get a bit off track and it can be quite easy to get off track if clients are in their own conversation. And I guess with a group in any group, you don't want one client to dominate the entire conversation. And you also don't want it to go off track, so that you are on some completely different discussion that isn't really useful for other people. So the objectives were really useful in terms of in your mind checking in. Is this following where we are going, and if it is already, then cool. We will use that and keep building and including other people. And if it is not, then we need to redirect it so they were really useful. It is also really easy to

put in things you might think are useful too. And I guess if that is not part of the manual, then you have to be really mindful about working to that. Otherwise it is just anything, isn't it. Rose

Rose thought about how easy it was for clients to become caught up in their own conversation. However, she also recognised the need for clients to work therapeutically during the sessions and to gain the skills they needed to implement into their lives. The manual is designed to impart information and has psycho-educational features. Rose was able to recognize a key therapeutic factor of the group was that the manual was purposefully imparting specific information as well as therapeutic goals and objectives. Rose reflected on the need to have a conversation and to allow it to develop in a natural way, but at the same time it had to have a purpose. Otherwise, some participants were not going to receive what they needed in therapy. As she reflected on the conversations, Rose recognised that she had used the manual's objectives as a tool to judge the participants' conversations and to ascertain if they were beneficial or not. In one-on-one sessions this would not occur. The conversation is only between the clinician and the client. In the group, all conversation has the opportunity to be useful, but Rose realised she needed to make sure it was. When she saw it needed redirecting, Rose guided the conversation back to the session objectives. Rose consciously imparted psycho-educational information to the group in a therapeutic manner. Rose did not think all the discussions the participants engaged in were necessarily helpful. She recognised a difference and distinction between engaged and helpful therapy.

As a result of facilitating the group, clinicians often found themselves in the position of governing the session. Their interaction with the participants often placed the participant in a subordinate position of power; otherwise the participants could end

up dominating the session and controlling its content to the detriment of other participants.

Costello (2013), report that the facilitators of their diabetes group identified three specific tasks in managing group dynamics. These included creating a positive environment, coordinating flow between reticent and dominant members, and holding back while fostering the group to enable peer and intergroup development and support. Stewart (2006) in their study of organisations describes the need for facilitators to help others. This is realised through effective facilitation and by encouraging participants' self-management of the group, rather than depending on the facilitator. The clinicians while conducting the groups in this study were aware of managing and controlling the conversations. However, encouraging the participants to become more self-managing and having control over the groups and the relationships within the groups appeared to remain outside of the therapists' reflections.

9.7 Evaluating the Session

The use of psychometric tools to measure client change in manualised programmes is common and this study similarly administered psychometric tools. However, the clinicians also used their clinical judgment, insight and clinical assessment when evaluating how the participants were responding to the therapy to determine whether clinically significant change had occurred. Clinical significance is defined as the degree the intervention effects change in comparison to the everyday functioning of the client (Kendall & Grove, 1988). Therefore, it was important to explore how the therapists evaluated their sessions. Usually, this was in a collaborative manner, such as Diane's account.

We would spend the whole trip coming back talking about it so a good at least half hour debriefing... and evaluate how that session really went, what worked really well, what didn't work so well, what we might do differently next time. Whether there were members of the group who seemed more particularly engaged. What we could do to bring the less engaged members back in for the next session. So yes we did quite a lot of time evaluating how the group went... And it was good because we were on the same page but then sometimes one of us would have picked up on something perhaps the other one didn't so that was nice as well. To be able to have two people be able to notice ... Diane

When Diane recalled her experience, it was the dynamic nature of their conversations as they talked after the sessions. Diane reflected on how involved the conversations were and how widespread their evaluation of the session was. Having the time to discuss a therapeutic session in this manner does not normally occur in one-on-one sessions where a clinician may have limited time to discuss a number of cases in supervision. In this situation, Diane was able to process events in therapy directly after the session with another clinician. As she reflected on this, Diane was aware of how good it was to have weekly input from another clinician and gain a wider perspective. Consequently, she became aware of elements that she had not noticed occurring in the group. Further, she was able to do this with someone else who shared the same therapeutic session. When she reflected on this, Diane realised she was accurate in her clinical judgment, but also gained the benefit of someone else's insight too.

Rose also gained valuable insight through having another clinician present to evaluate the session.

The other clinician and I would debrief, after each session and we would think about what we would of thought were important aspects to bring up at the next session. And whether there was any need to follow up on anything we needed to do in terms of the content of that session. But really that was our debrief with each other and it wasn't a formal evaluation as such.... We would talk about what had gone on and processed stuff that had happened. Then we would, with a view to what

...we might run in the next one, or we would have particular things we would have needed to address at next session. So, we went through each person and debriefed on their input and what we thought was going on and what was useful and what wasn't useful.... We would think about whether the people had enjoyed a particular activity or whether people looked like they were interested in it, or what people's comments were about things as we went along. But again we didn't document this kind of stuff either. It was our perspective of it. So and so seemed to really enjoy that piece, and maybe someone else didn't pick up on that, or looked like they didn't quite understand that. Maybe we want to revisit that again.

Rose

Rose and the other clinician also debriefed directly after the session. They used their time together not only to evaluate the participants' responses but also to forward plan for the next session. Rose considered multiple aspects of how she evaluated the programme. She thought about how participants responded to content, how the session may have benefited the client, and what needed to occur next. Rose was aware that her evaluation was not a formal process, but it was nevertheless valuable as it impacted directly on participants care. Rose considered while psychometric tools are helpful, they do not provide answers to all the facets which occur in a therapeutic setting. As she evaluated what had occurred, Rose continued to formulate treatment and consider participants' individual needs. Claire thought about evaluation from two perspectives. Firstly, as with Diane and Rose, she considered aspects of the manual and how the participants were responding to material. In her second account Claire reflected on what the participants articulated about the programme.

And absolutely looking at their buy-in, investment or I guess engagement with the topics we were covering and the kind of work we were doing. Also how it was fitting for people who were attending who were there for a variety of different reasons as well and whether they were helped. And how relevant it was to those participants in each session as well.... So there were aspects (of the manual) that worked well. One was the group exercises and to be honest I was a little bit dubious about how they were going to go and actually they went well. People did really well, they were

*quite involved with them and the exercises and it was a good ice breaker for the sessions and created some humour as well at times you know writing with the other hand and so they were good. And it is good to have guides, the way it guides the clinician in terms of what to say and the order in which to do things that is a strength of the manual I think. And it is also a strength that you can, somebody new can have that there to use but you don't have to use it. You can use your own words or descriptions for things as well. That's a nice component of it... **Claire***

Claire also reflected on how her thinking changed. When she had initially considered elements in the manual, she anticipated the possibility that components might not work. When they did work well, Claire reflected on how involved the participants were and whether the exercises drew participants into engaging with each other. As she reflected Claire realised other parts of the manual structure and layout were also beneficial in aiding the clinicians in helping the participants engage in therapy. As she thought about the manual, Claire realised the manual was suitable for clinicians with a wide range of experience from novice to skilled clinicians. Claire's insight into how she evaluated the sessions was she had doubts about components of the manual but changed her thinking to realising it was a tool most clinicians could use.

In her second account, Claire considered the participants' actual responses to being asked about the therapeutic group sessions.

*We were asking them for their feedback and certainly encouraged them at the end as well, that they had the opportunity to give feedback if they wanted to. And have implications and direct effect on how the manual was developed further down the track. So they could use their experience to guide how we did this planning for how other people might find it in the future as well... **Claire***

Claire reflected on how important it was for her that the participants could affect the structure and programme of the groups. This is not unexpected as her core value as a clinician was to ensure participants' needs were met. She wanted to directly know the

participants' experience. She had spent time thinking about their responses, their engagement with the material, and had spoken and debriefed with the other clinician. But Claire wanted to gain a deeper understanding and insight into what the group was actually like for the participants. Claire realised the unique and valuable perspective the participants had, was not able to be gleaned during the manual development. By gaining their views, Claire realised the manual could be further shaped to meet the needs of future participants.

In summary, the gap between practice-based research and published results is evident in this theme. How clinicians make therapeutic decisions in a session, evaluate participants' responses, and assess treatment usually relies on evidence-based practice and psychometric tools. The therapists in this study used intensive and extensive feedback with each other regarding the sessions and the participants. Further, they actively sought participants' feedback as well on the session's content and effectiveness. This poses the question of whether there are levels of processing of a therapeutic relationship for the therapists and whether a collaborative approach has an impact on outcomes.

The therapeutic value and the effectiveness of using a collaborative approach in therapy which the clinicians experienced parallels with family therapy research. Family therapy research findings include concepts such as how a therapist can turn over power to a group, generate new ideas, encourage insight to bring about change, and promote an active learning environment, through the use of reflection and feedback from other members of the group or co-facilitators (Harrawood, Parmanand, & Wilde, 2011).

9.8 Summary

In this chapter the experience of three clinical psychologists working in the HCPS were explored. The themes of *meeting the individual participants' needs*, *becoming a group facilitator*, *managing a group*, *preparing for the session*, and *evaluating the session* emerged along with accompanying sub-themes. The therapeutic environment consisted of a multitude of relationships with the clinicians attending to the individual needs of each participant. It is possible they were able to accomplish this more easily given the small participant numbers in each group. With regards to the group process, the clinicians talked about the satisfaction they found in working with groups despite none having previously run a therapeutic group. In general, through their experiences as facilitators, the clinicians became more aware of group processes and social support available in groups. However, they talked about group processes as they occurred with individuals rather than global group processes.

Also, the clinicians' perspectives provided insight into their experience of facilitating a therapeutic group. The clinicians described their core value for the therapeutic group was providing individualised care and prioritised the individuals' needs within the group and adapted to meet client needs. They understood the need for care and considered multiple aspects in order for the therapeutic care to be effective. Hudon et al. (2012) state the need for patient centred care especially in long term CHC care. The findings tentatively suggested that the clinicians found the therapeutic group setting differed from other settings, when compared to one-on-one therapy, and couples and family therapy. In addition, they worked proactively and anticipated issues and problems which may have arisen within a therapeutic group setting, such as, conflict

between participants and engaging reticent members. There were two facilitators in each group. An awareness of the different competencies of each clinician and how the clinicians worked collaboratively and with mutual acceptance as a team were not identified within the questions and framework of the study. Lau, Ogrodniczuk, Joyce, Sochting (2010) and Sochting and Third (2011) criticised current group therapy research as having limited practical clinical utility. Specifically, practice-based research needed to consider further, among other priorities, group processes and group leader issues. This was evident in this research whereby clinicians' experiential perspectives of therapeutic groups were difficult to locate.

However, in using the manual, the clinicians also faced challenges in bringing about therapeutic change for individuals in a therapeutic group setting. They were able to use the manual to aid discussions and group exchanges. But in some instances, they found that it was difficult to adhere strictly to the manual, while simultaneously meeting the participants' needs. This suggested that the clinicians valued the ability to work flexibly even when using a manual. Garmy, Berg, and Clausson (2014) similarly found in their implementation of a CBT group therapy by school health professionals that facilitators tried to balance manual adherence with meeting participants' needs. What is unclear from this study is how the clinicians considered fidelity when dilemmas arose in following the manual. Manualised therapy, while providing a medium for evidence based therapy, can have the drawback when followed slavishly. It may prevent the facilitator from using the group process to engage in relevant issues presented in the group. At the same time, departing from the prescribed therapy may interfere with effectiveness. Doel and Kelly, (2014) suggest the manual can be followed in essence,

with the manual being flexible enough to amalgamate the material and group process into a useful experience for the participants. However, they also recommend facilitators need to have specialist group knowledge, training and skills; otherwise the material is likely to be administered in an academic rather than therapeutic manner, which would reduce participant's effective outcomes.

The issue of attending to the group process is complex and highlighted by this study. The question arises for therapeutic group practice; how do clinicians identify and develop group process skills as they experience and implement therapy in a group setting? In this study, clinicians' core values played a role, as they considered the individual client needs were paramount. Yalom and Leszcz (2005) discuss a two tier approach for facilitators to bring effective change in groups when working in "the here-and-now." Firstly, they need to attend to the immediate events in a session, especially the dynamic interrelationships occurring in a group. The next tier is a self-reflective examination process of the "here-and-now" experience which has occurred. They discuss that in most groups, the facilitators attend to the first aspect, but few facilitators consider the group process. Further, they infer it is only through the facilitators gaining experience with groups that this can occur (Yalom & Leszcz, 2005). The facilitators' experience is an area in group research which is seldom discussed.

CHAPTER 10 MAIN OUTCOME MEASURES

This chapter reports the psychometric test results used in the groups. Due to the small number of participants, it was not possible to analyse the results using inferential testing. Thus, it was decided to report results consistent with their use in a naturalistic clinical setting. For the purpose of anonymity, participants are referred to numerically with the same number allocated to an individual in all the figures discussed in this chapter. All the group participants' psychometric results are reported, although not all the participants chose to be interviewed for this study. The psychometric tools were administered in the manner intended for their use. While a psychometric profile of participants at the start of the programme would have been helpful, it was not possible to access previous data collected by the clinic due to client confidentiality and consent processes.

The therapeutic groups were administered three psychometric tests including the Outcome Rating Scale (ORS; Millar Duncan, Brown, Sparks, & Claud, 2003), the Short Form-12 (SF-12; Ware, Kosinski, & Keller, 1996), and Hospital Anxiety and Depression Scale; (HADS; Zigmond, & Snaith, 1983).

In a clinical setting it is usual for client change to follow a non-linear progression with fluctuating psychometric scores. However, over time improvement from intake scores is expected with the majority of individuals showing improvement by the eighth session (Lambert, Garfield & Bergen, 2004).

10.1 Hospital Anxiety and Depression Scale Results

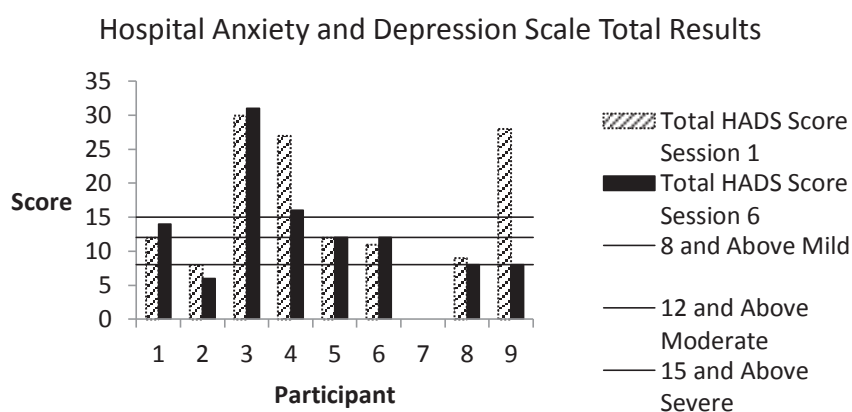


Figure 1. Comparison of participants' scores from session 1 and 6.

Scores from Figure 1 show participants four and nine reported fewer items for their scores in session six compared to session one. Despite reduced scores, participant four's scores remained in the clinically severe range in session six. Participant nine was in the severe range in session one, but by session six endorsed items which placed them within the normal range. This indicated a reduction in both depression and anxiety symptoms in session six. Participant seven scored zero on all items on the HADS. It is unclear whether this was an accurate reflection of their anxiety and depression symptoms, they did not understand the instructions, or did not have time to complete the psychometric test. However, the other psychometric tests were completed; therefore, participant seven's scores are not considered in the HADS results. The remaining participants one, two, three, five, six and eight, reported slight variance in their scores from session six in comparison to their session one scores, indicating a stable result overall. In session six, participant one reported two more items and participants three and six, one more item. Participants two and eight reported two items less in session six,

while participant five's scores remained the same. Two participants, eight and nine reduced their clinical range scores on the HADS from mild and severe range respectively, to clinically normal range. The remaining participants did not change their levels of clinical severity.

Usually the items from the two HADS scales are combined to give a total score and descriptors used range from normal, mild, moderate to severe.

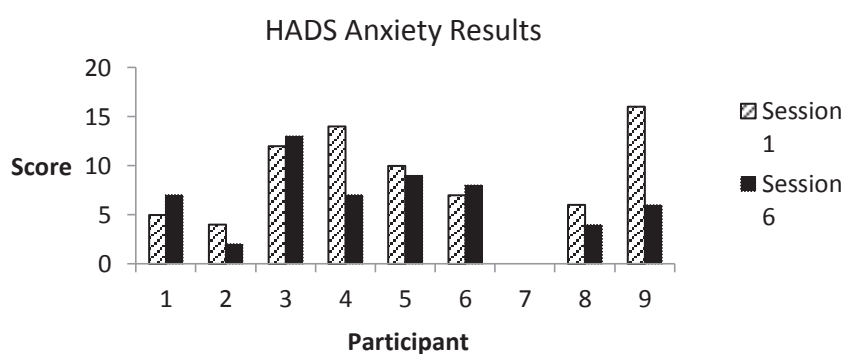


Figure 2. Comparison of participants' Anxiety Scale scores from session 1 and 6.

Given that the theme of feeling apprehensive arose in the thematic analysis; the HADS individual scales were examined to investigate whether clients had elevated anxiety symptoms at the therapeutic group onset. The results in Figure 2 above indicate that most of the participants endorsed multiple items on the anxiety scale with only participant two and seven endorsing four or fewer items at the start of the group. Further, based on their session one scores on the anxiety scale, participant five would have met HADS clinically mild criteria, participants three and four would have met HADS clinically moderate criteria, and participant nine would have met HADS clinically severe criteria.

In comparison to session one, at the end of session six, participants three and six endorsed one more item and participant one endorsed two more items. Further, participants two, four, five, eight, and nine also endorsed fewer items. Participants two and eight reported two less items, and participant five one less item which along with participants one, three, and six scores, suggested a relatively stable result. However, both participants four and nine endorsed seven and ten items less on the anxiety scale at the end of session six, indicating a reduced level of anxiety. Based on their anxiety scale scores, at the end of session six only participant three would have met HADS clinically severe criteria.

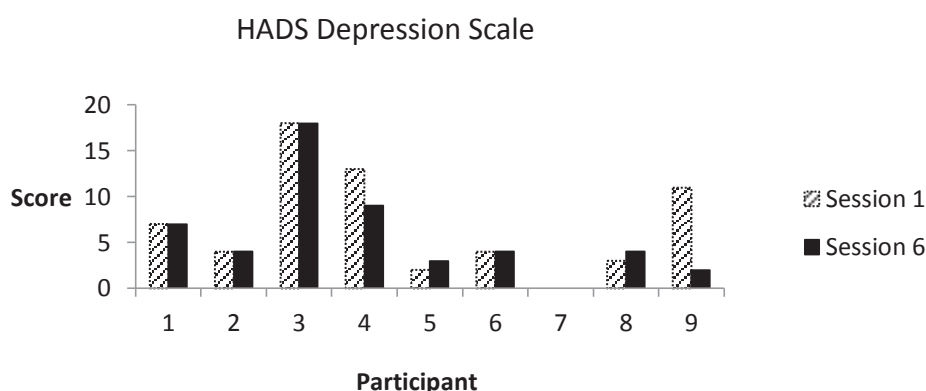


Figure 3. Comparison of participants' Depression scale from session 1 and 6.

The scores as shown in Figure 3 indicate that participant three based on only their session one scores, met HADS criteria for severe depression, participants four and nine met HADS criteria for moderate depression. Participants one, two, three and six endorsed the same number of depression items in session one and session six. Participants eight and five had an increase of one endorsed depression item, but overall endorsed few depression items. Participant nine endorsed 11 items at the beginning of

session one on the depression scale but only two items in session six. Participant four endorsed 13 items on the depression scale at the beginning of session one and nine items in session six. As with participant nine's previously reported anxiety results, the number of endorsed items reflects a decrease in reported depression symptoms from session one to session six. Based on their scores at session six, participant three met HADS criteria for severe and participant four met HADS criteria for mild depression.

10.2 Outcome Rating Scale Results

Figure 4 presents the participants' ORS results with scores below 25 being clinically relevant; meaning if the participant is not already in treatment, they should receive either a mental health assessment or treatment. The ORS measures levels of distress across four domain scales; personal well-being, interpersonal, social and an overall scale.

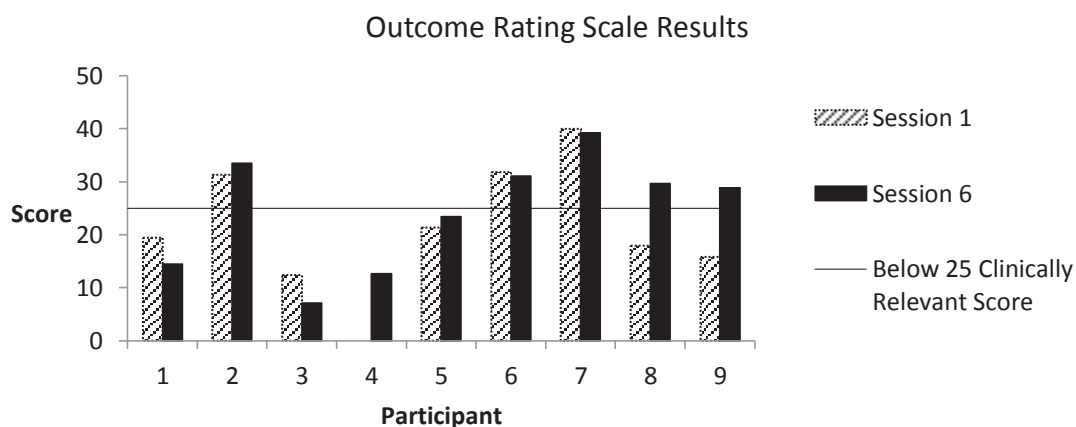


Figure 4. Comparison of participants' Outcome Rating scale from session 1 and 6.

Similar to the HADS, most of the participants' scores on the ORS psychometric test were relatively stable between sessions one to session six. Because participant four did not complete session one ORS forms, it is unclear whether they showed

improvement or decline over the sessions. Five other participants scored below the clinically relevant score of 25 at the start of the therapeutic groups and four participants scored below the clinically relevant score at the end of the groups. When viewing their original scores on each of the ORS' four domains, participant one and three reported a decrease on the interpersonal and overall scale. Participant five reported an increase on the social and overall scales.

Participants eight and nine had notable increases in their scores bringing them from the clinical to non-clinical range. When viewing their original scores on each of the ORS' four domains, participant eight reported an increase on all the individual scales but especially the interpersonal (family, close relationships) scale. Participant nine reported a significant increase on the interpersonal (family, close relationships) scale.

10.3 Short Form-12 Results

The SF-12 generates two outcome scores namely the mental and physical health scores. The scores are presented as comparing with other people of the same age. As mentioned previously, scores under the value of 50 on both items are considered to indicate functioning levels lower than 50% of the population. The lower the score, the more severe impact a chronic illness is impacting on a participant's well-being.

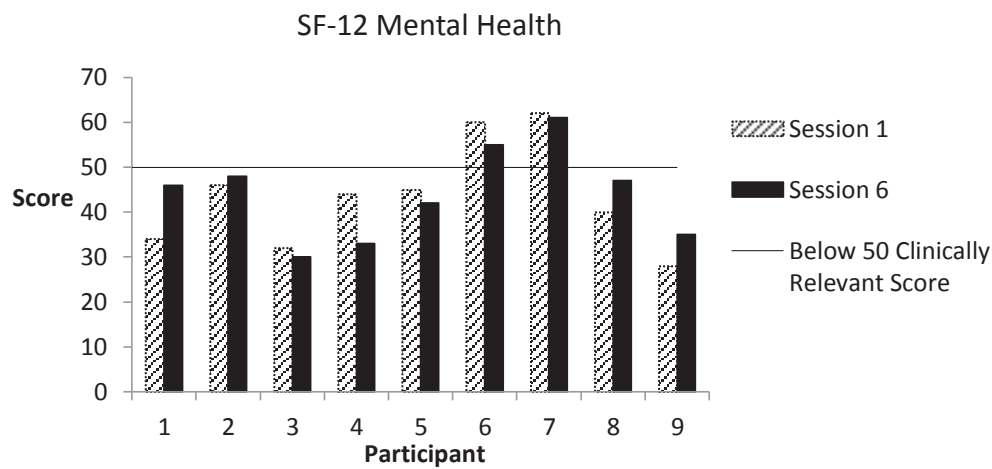


Figure 5. Comparison of participants' SF-12 mental health score from session 1 and 6.

As shown in Figure 5, the results of the SF-12 Mental Health scale were mixed, although differences between scores were minor, suggesting stable results. At the beginning and end of the therapeutic groups, participants one, two, three, four, five, eight and nine had SF-12 Mental Health scores below the 50th percentile meaning they were worse off than half the population of a similar age. Participants one, two, eight and nine showed an improvement from session one to session six. Participants one, eight and nine showed an improvement of between 5 to 12% on the SF-12 Mental Health scale with participant one showing the most improvement. Participants three, four, five, six and seven showed declines in their SF-12 Mental Health scale results. Participant four, five and six showed declines of between 4 to 11% with participant four in comparison showing the most decline on the SF-12 Mental Health Scale.

The results of the SF-12 Physical Health scale as shown in Figure 6 were also mixed although changes in scores were relatively small.

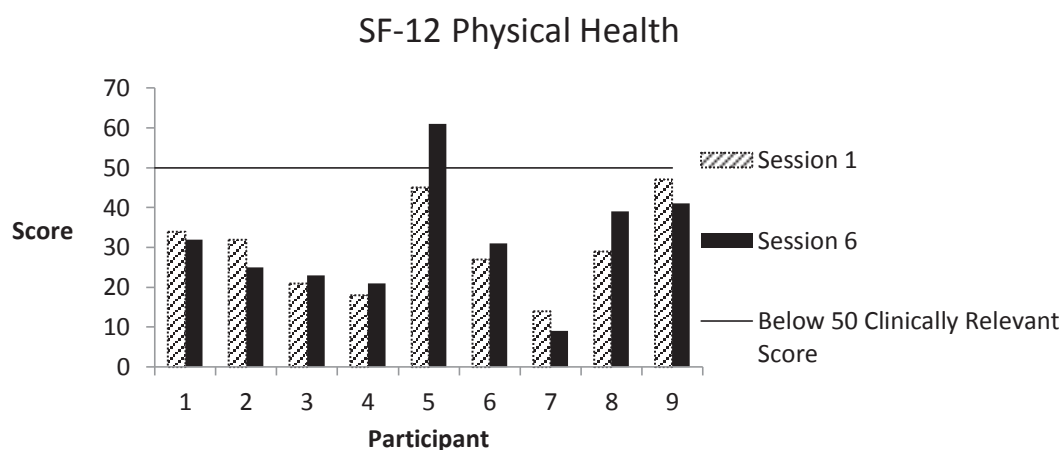


Figure 6. Comparison of participants' SF-12 Physical Health from session 1 and 6.

Participant three, four, five, six and eight showed an improvement on the SF-12 Physical Health scale. Participants four, five, six and eight showed an improvement of between 4 to 16% on the SF-12 Physical Health scale with participant five showing the most improvement. Participant five was the only participant to have a score higher than 50% of the population. Participants one, two, seven and nine scores declined on the SF-12 Physical Health scale. Participants two, seven and nine's scores declined between 5 to 7% with participant two reporting the most decline.

When comparing the SF-12 Mental and Physical Health scales with each other, participant one showed the most improvement on the SF-12 Mental Health scale and participant five the most improvement on the SF-12 Physical Health scale. Participant four reported the most decline on the SF-12 Mental Health scale and participant two the most decline on the SF-12 Physical Health scale.

10.4 Summary

This chapter presented results from three psychometric tests administered to the therapeutic group participants. While some data was missing, participants' scores remained stable with minor variance in their scores from session 1 to session 6. Only two participants showed improvement on the HADS, the only measure which specifically measures depression and anxiety. However, on the ORS some participants showed an improvement on their interpersonal relationships scale especially. Results overall suggest participants who were at a severe level on their psychometric tests remained at the same level, as did participants who reported less severe symptoms.

CHAPTER 11 PARTICIPANTS' FINDINGS

Data from the interviews, having conducted a thematic analysis, saw four major themes identified with sub-themes emerging. The themes included *initial experiences of joining the group, the influence of experiencing group support, improved relationships with health professionals, and using the therapy.*

Initial Experiences of Joining the Group

Feeling apprehensive

What it was really like

Better off than others

The Influence of Experiencing Group Support

I am not alone

Others need to try harder

Others may have got more out of the group

Improved Relationships with Health Professionals

Using the Therapy

Denial of illness

To maintain the principle of anonymity, and in recognition that the responses are the lived experience of participants, pseudonyms were used to illustrate quotes rather than using data codes.

11.1 Initial Experiences of Joining the Group

Some of the participants were familiar with the HCPS and had received one on one therapy. However, in reality, participants are likely to have service provision for their CHC from a range of health providers. They are not necessarily naïve to psychological interventions but may not have recognised them as such when it was conveyed to them. For the purposes of this study it was important to consider the experiences of the group from a participant's perspective and whether the participants' therapy, as outlined in the treatment manuals, was relevant. Aspects that needed consideration included how the participants perceived their difficulties or reasons for attending the group, and whether therapy was consistent with their expectations of what the therapeutic group experience would provide. Another key aspect was how the participants related to each other. Burlingame et al. (2001) state that how group members relate to each other and to the group as a whole is one of the primary therapeutic mechanisms for individual therapeutic improvement. McElvaney and Timulak (2013) state that other factors such as the therapist's style, generating new perspectives, emotional relief, and clients developing knowledge and resolving their problems, can improve outcomes for clients. Conversely, unhelpful factors include concerns about feeling vulnerable, a lack of commitment or motivation to therapy,

uncertain expectations, and barriers to feeling understood (McElvaney & Timulak, 2013).

In this study, the first theme identified by thematic analysis was related to initial experiences of joining the group. Three sub-themes were identified: feeling apprehensive, what it was really like, and I am better off than others. In these sub-themes the social environment and social comparisons within the group were key areas of significance for participants.

11.1.1 Feeling apprehensive.

Burlingame et al. (2004) commented that a primary rationale for therapeutic groups is that they provide an important setting for establishing beneficial social relationships during treatment. Forming impressions of each other is part of the process of establishing social relationships (Marcus & Holahan, 1994). Group research as previously discussed, indicates that therapeutic outcomes are impacted by an individual's ability for interpersonal relatedness (Joyce, Ogrodniczuk, Piper, & Sheptycki, 2010; Kirchmann et al., 2009). Thus, for this study, participants' initial thoughts concerning the group were important as they directly influence treatment effectiveness and treatment evaluation.

Although one participant commented they were unclear why they had been referred to the groups by their health professional, other participants were similar in their responses of feeling apprehensive. When asked their thoughts about their experience prior to attending the group, it was clear participants were concerned with the social environment. Specifically, what it would be like meeting a new group of people. When considering the group context, participants were focused on their own

individual experience rather than the group experience. This appeared to be a time of self-reflection for individual participants. Importantly, participants did not discuss at the interview their health condition, the reasons for referral, or what benefits they thought they would gain from the group at the interview. Instead, joining a group aroused qualms and doubts about potential social interactions. Participants reported varied experiences and concerns with meeting new people and spoke of “not knowing anyone” and of groups being “out of their scope” and they were “wary” of groups.

Some participants had insight into their apprehension. One participant realised it was difficult for them to form social relationships in a new setting. Ralph had never married, lived rurally, and he worked alone.

...I dunno a bit of trepidation I suppose, because you're not quite sure. I'm not good in groups of new people to start with... **Ralph**

Ralph lived a socially isolated lifestyle, and entering the group highlighted a problem he had forming social relationships. He found it especially difficult meeting new people. His thoughts of not being “good” in these situations triggered assumptions that evoked a degree of anxiety and fear.

In two other accounts, participants' insights into their apprehension about forming social relationships in the group were linked to their current social experiences. They anticipated their difficulties in their pre-existing social environment would occur within the group context.

Jan faced uncertainty in her problematic relationship with her husband and entering the group also aroused feelings of uneasiness.

Of course, I didn't understand originally how it would evolve, sort of thing...I sort of wasn't sure what to expect... You were sort of treading

water...but it was sort of like, introducing yourself to a stranger and the path was unclear... **Jan**

Jan characterised her husband as being volatile, moody and a bully. She experienced persistent strain in her marital relationship and described her relationship as “living on eggshells.” Her marital relationship evoked thoughts and feelings of insecurity and unpredictability which she anticipated would also occur in the group. She expected participants to be capricious. Jan lacked trust in the group and was apprehensive about what would occur during therapy. Her experience of apprehension towards the group was marked with doubt and uncertainty.

Mary's insight into her apprehension was also linked to her pre-existing negative social environment.

...I've quite often shied away from group things because they can be, I don't know, just moaning sessions. People can be very negative and if everyone's negative in the group it can be quite hard. **Mary**

Mary had a lifelong CHC and she became socially isolated when her health declined and she stopped working three years prior to attending the group. She lived on her own and aside from health professionals, interacted only with her elderly mother and sister. She described both of them as being highly critical of each other and her. Mary's previous workplace was also stressful with multiple fractious interactions between other staff. Mary had difficulty being assertive when faced with disparaging comments and said she avoided her family as much as possible. Despite never having attended any previous groups, she assumed the group would affect her mood, especially if the group experience was negative. For Mary, her apprehension about what the group would be like evoked similar emotional states she experienced with her family and she wanted to avoid feeling hopeless and despondent.

Other participants, such as Ann, had limited insight into their apprehension.

...I was really quite apprehensive about it, because I really didn't know what I was going into... **Ann**

Her account did not reflect the origins of her thoughts or emotions about either herself or the group, yet of all the participants Ann was perhaps the most apprehensive prior to joining the group. She noticed she was “really quite apprehensive” and reflected an underlying sense of anxiety about not being in control, and also a fear of the unknown.

The sub-theme of feeling apprehensive gave a brief understanding of how participants were contemplating the group and preparing themselves prior to the first session. It was evident from the participants in this study that uncertainty about interpersonal relationships with other participants evoked feelings of apprehension. Further, their uncertainty was based, in part, on their current interpersonal relationships and social environment outside of the group. Concerns about what would occur during the therapeutic group also existed. Evidence supports the existence of sequential stages of group process development, for example, Brabender and Fallon (2009) and Burlingame et al. (2004). Yet a search of the literature was unable to locate examples of qualitative research of health group therapies which considered participants' experiences of their expectations, and especially negative expectations prior to attending a therapeutic group. Baker et al. (2013) suggested client characteristics predict a client's outcomes in therapeutic groups, including interpersonal skills and whether clients expect to benefit from group therapy. Further, Bernard et al. (2008) highlighted that participants' resistance to group therapy may include apprehension and uncertainty about the usefulness of therapeutic groups. They suggested clarifying expectations,

structure and group framework as ways a clinician may alleviate apprehension (Bernard et al., 2008).

11.1.2 What it was really like.

The second sub-theme to arise from *Initial Experiences of Joining the Group* focuses on *what it was really like*. In this sub-theme, as with the previous sub-theme of *feeling apprehensive*, participants again focused on their individual personal experience rather than a group or health condition experience. However, in this theme, participant narratives revealed that their focus when they attended the group was on self-appraisal and how they would be evaluated by others in the group. Participants' accounts reported concerns of impressions they would make and how they would compare to other participants. This was a significant result as social comparison and the way in which individuals compare themselves to others in a group can influence emotional states and in turn, may impact on the way that a CHC is managed (Hillsdon, Kersten, & Kirk, 2013).

Initially, Tom thought about what the other members of the group might be like. However, he later became more introspective and began to consider what impression he would make on the other group members.

The initial thing with the group was who am I going to meet?... They might think I'm cuckoo or I'm this, I'm that... Tom

Tom experienced not wanting to be judged for his illness or depression. The way in which others reacted to him was important, especially, what they would assume about him and how they would regard him as a person. He was aware he was attending a psychological Service and did not want to be stigmatised nor did he want his CHC to

define him as a person within the group. Tom's experience of what it was really like for him meant that he wanted others to consider him in the same way that he identified himself. His thoughts and concerns about being negatively evaluated occurred despite his understanding that everyone else had also been referred for difficulties with managing a CHC.

For one participant, the impact of her CHC resulted in increased social isolation from her friends and family. When she compared herself to the group, Ann thought about what made her different and saw these differences as barriers.

I don't think any of us had anything in common, ah plus having the different age groups as well... I mean if they had requested it I would go and have a coffee or something like that... But I don't think they would, because we're in completely different circles. Ann

Ann spoke about her loneliness, her lack of trust in her family being there for her, and not being able to socialise like she had in the past. Ann's CHC changed how she related and interacted with people and this had a profound effect on her life. Her experience of isolation and not being able to join in with her family was reflected in her account of what the group was really like for her. This meant she was not able to be open and vulnerable with the group. She assumed the overt group differences and her CHC would prevent others in the group from interacting socially with her, in a similar way to her family. This raises an important consideration about what it must be like for socially isolated people such as Ann to overcome barriers in joining a group, and what factors prevent them from gaining social support from within a group. Ann experienced a disconnection and felt estranged from the group, and in comparing herself to the other group members perceived no commonality with anyone. Importantly, neither Ann nor any other participant mentioned any common goals they had with each other. Ann also

commented on the low participant numbers so it is possible her sense of being different was further highlighted by this. Had there been more participants, Ann may have connected more readily with other members.

Another participant, Fran, struggled with accepting her need for help. She recalled thinking she didn't need to attend the group as her problems had lessened before the group started. Initially, she compared herself with other group members and felt pride that she was managing her CHC and not needing psychological help.

Oh, it was alright (going to the group). I thought I was better than them, but then I still got taken down a peg or two, and I thought "that's horrible, isn't it"... **Fran**

Fran's comparison of herself with other group members enabled her to view herself more positively and in turn reduced the impact of her difficulties. This is supported by research which purports that psychological distress associated with health problems may cause an individual to compare themselves to others, with others being considered worse off than they are. Further, it is often regarded as a way of improving an individual's self-esteem (VanderZee, Buunk, DeRuiter, Tempelaar, & Sanderman, 1996). Fran's reflection on the group highlighted for her the overt needs other people had. However, the nature of her comparison with the group changed over time. She began to recognise similarities between herself and other people and this made her realise her problems required help just as others did. When this occurred she experienced feelings of embarrassment and humiliation. In her experience of what the group was really like, Fran went through a process in which she began to identify her own less explicit needs that she had previously failed to recognise and acknowledge.

In summarising the sub-theme *what it was really like*, the participants' experiences were diverse. Participants reflected on how others perceived them and also about their initial impressions of other members.

Consistent with the previous sub-theme, qualitative health research on participants' experiences of adjustment and group cohesion during the early stages of a group are lacking. This is important, as overall therapeutic outcomes are related to group cohesion (Burlingame et al., 2001). Further, dropout rates from group therapy tend to occur during the early stages of therapy (Burlingame et al., 2001). However, some studies reported positive relationships and the existence of a non-judgmental social environment. In groups such as these, participants made social connections to gain an overall sense of belonging which meant they could self-reflect on their illness. This occurred in studies of conditions, such as, hepatitis C virus (HCV) (Woolhouse, Cooper, & Pickard, 2013), COPD, (Halding, Wahl, & Heggdal, 2010), and diabetes, (van Dam et al., 2005).

11.1.3 Better off than others.

Not being as "worse off" as others in the group, was a direct quote by three participants and being better off than other participants was a common perception. Despite their own significant issues, they thought others' problems were worse than theirs. In this sub-theme, individuals continued to self-reflect in comparison to reflecting on the group as a whole. Accepting the need for psychological therapy for their CHC required participants to acknowledge their health and associated problems. Many of the participants had been socially isolated and individuals in their support network did not have significant health issues. As a result of being able to socialise in

the group setting with others with a CHC, participants experienced being with people with similar health difficulties. Several participants reported similar experiences of normalising their problems and realising that they were better off than others.

Consequently, some participants thought because the other people were worse off than them; they were more “worthy” of receiving resources or help than they themselves were. How the participants initially perceived their problems at the start of the group is important, as it may have impacted their attitudes towards, and acceptance of, the therapies used in the manuals.

Ann had major surgery for her heart condition, continued to smoke and was non-compliant with monitoring her diabetes. She realised she was not the only person with problems but had rationalised that her problems were not as significant.

I mean we always know we're not the only ones with problems; there are always people worse off than us... Ann

In underestimating her difficulties, she was able to avoid facing the possible consequences of her CHC, including a shortened lifespan. However, in minimising her problems, she also underestimated the problems faced by other people in the group. Despite other comments in Ann's narrative which show she distanced herself from the group, in this situation Ann considered the group and herself as one entity. Ann continued to deny the extent of both her and other group members' difficulties.

Ralph also considered his problems were minor despite having an untreated diabetic ulcer for which he had not sought treatment. For Ralph, type 2 diabetes remained a hidden, silent disease which he could ignore, and which did not cause him undue harm.

*But, I didn't think that I was seriously enough ill or anything...The nurse referred me and I thought well I'll go, because I've only got the type 2 diabetes. The other people there were more ill than I was as such. Yeah, they were. They had some real problems, you know, with their health, and mine was only sort of, seemed to be minor, really... **Ralph***

When he reflected about the group he was able to recognise other participants' difficulties and indeed the seriousness of the problems some participants faced. He experienced astonishment and surprise at how ill some of the participants were, but did not reflect on or consider his diabetes might cause similar issues in the light of their problems, or indeed why his health professional had referred him. Ralph remained unaware of the reality of the consequences of his diabetes and that he could potentially face health consequences similar to other participants. It was possible that by denying the consequences of his illness, Ralph was able to carry on and not become overwhelmed by the serious nature of his illness. He may have used denial as a coping mechanism for his illness.

Another participant who initially perceived the other group members as worse than him was Tom.

*Really in my situation due to back problems and this and that. Trying to find a job, and financial pressures, and this and that. There are a few others that are even worse off than I am... **Tom***

Despite having a supportive family, Tom had struggled with the effects of his CHC's impact on his life, leading to a period of depression. When Tom reflected about his situation, he accepted his health issues and furthermore, he recognised his difficulties were not only because of his CHC. When Tom reflected about his experience in the group, he recognised other people also had significant problems. Tom was able to experience a change in the degree that his health impacted on his mood.

Rather than deny that his health impacted him, as with Ann and Ralph, Tom, by comparing his problems to others in the group, was able to reduce the impact that his CHC had on him. Tom experienced empathy for the other group members and was able to minimise the other problems he had such as being unemployed. Tom mentioned the impact of his illness on his employment prospects and this was unique among the participants.

The sub-theme *Better Off Than Others*; participants compared themselves to other members and saw themselves in a more positive light. VanderZee (1995) suggested social comparison allowed individuals to normalise their health issues and increase their perceptions of control over their illnesses and their ability to cope. Similar findings were found by Scope, Booth, and Sutcliffe (2012) in their study of women's experiences of a CBT group therapy for Post Natal Depression. They found their participants had contrasting perceptions and experiences of the group, especially the participant's ability to normalise their thoughts towards their Post Natal Depression (PND). It was unclear how long their participants had PND before entering the group. However, in contrast to this study's results, their participants identified that other group members' improvement in functioning was helpful to their recovery. Participants in this study gained hope from their perceptions that they were initially healthier than others and did not appear to notice whether other participants improved as the group progressed. Individuals assess themselves and use social comparison as a means to interpret health risks, make health decisions and see how they adapt to a CHC. Often it is difficult to make objective self-evaluations and individuals evaluate themselves through comparing themselves to others. Downward social comparisons occur when

individuals improve their subjective well-being by comparing themselves to others they perceive as being worse. Consequently, they see themselves as being better off than others (Gorawara-Bhat, Huang, & Chin, 2008). Research has identified that people compare themselves with others as being worse-off in order to make themselves feel better (Tennen, McKee, & Affleck, 2000), and this has been documented among individuals with a CHC (Buunk Collins, Taylor, VanYperen, & Dakof 1990; Hemphill & Lehman, 1991).

11.1.4 Theme summary.

When considering the theme and sub-themes of *initial experiences of joining the group*, participants in this study experienced apprehension about joining the group.

When they attended, they thought about how others would perceive them and they also thought they were not as “worse off” as others in the group. Their unique experiences of wariness and negative perceptions of others as they were adjusting to the group during the early stages, suggested cohesion with other participants in the group was possibly lacking. At the same time, participants compared themselves to other members and perceived other group participants negatively, which enabled them to improve their perceptions about their own problems and health.

In general, health research which considers the initial experiences of joining a group from the participants' perspective is scarce. Fuhrman and Burlingame (1990) state client characteristics are important in groups and the ability to trust and form beneficial social interactions are crucial.

11.2 The Influence of Experiencing Group Support

Participants were asked if their needs were met and how effective they felt attending the group had been in helping their situation. The impact and role that social support had on participants within the group was evident from their responses. Both perceived and actually received social support is widely recognised in the literature as a major factor in therapeutic groups, and is associated with positive outcomes for participants (Harel, Shechtman, & Cutrona, 2011). Participants related the way in which the group experience helped them to gain new insight into how others coped with their situations and the effects their CHC had on their lives. When considering the group context, participants focused on both their own individual coping as well as how others in the group were managing their CHC. This appeared to be a time when participants actively reflected on the impact of being in the group from a social perspective. The three sub-themes which emerged were *I Am Not Alone*, *Others Need To Try Harder*, and *Others Got More Out Of It Than I Did*.

11.2.1 I am not alone.

The interviews revealed that participants experienced social support and a sense of “not being alone” in the group from a variety of different perspectives. Participants spoke of “not being alone” “being amongst others” and how others “felt the same” as they did. This is supported by the literature which recognises social support is multidimensional and encompasses different factors. Further, effective support is dependent on the different types of support provided, matching the coping resources and demands of the stressor on the individual (Mallinckrodt, 1989). Participants expressed

distinct perspectives in which some actively recognised the impact of group support on their problems, while others recognised the impact on their wider social life.

Tom's loneliness developed from spending significant periods of time on his own unable to leave the house while his partner worked. Tom had recently moved cities. He felt he had few people in his life who understood the way in which his CHC left him feeling a lack of support and isolated and alone. Importantly, these problems faced by him further exacerbated his depression.

It made me aware that I am not the only one in New Zealand who has got a problem, and yeah I have learned to kind of live better with it. I have come to terms with the fact that there are others... Well look, seeing the other people with their own problems, it made me aware that I am not the only one with a problem out there... Tom.

Tom's awareness of others in the group with a CHC gave him insight into the fact that he was not the only one managing a CHC. Seeing others with a CHC gave him a sense of camaraderie and examples of alternative role models within the group of coping with a CHC. Tom found by being in the group he was not alone anymore and this gave him a sense of support. The camaraderie he received enabled him to reframe the way in which he thought of himself, and his ability to positively manage his CHC.

Jan had also struggled with feeling alone. However, her loneliness was the result of what she perceived was an unsupportive husband and family. Jan realised she was with other people who understood her difficulties, unlike her family.

Well I was amongst other people who had something wrong. That I didn't even need to know or want to know but they had their problems and so did I... Yes. And in being able to say something, and being listened to without being right or wrong. So yes, that's the help. Because there were people there, you know a place to start... Jan

Jan struggled with feeling rejected and felt her family lacked empathy for her due to her not managing her CHC. When she realised she was not alone in managing a CHC, Jan felt a sense of acceptance in the group. Jan experienced being able to identify with the group rather than the isolation she experienced in her home environment. Importantly for Jan, the type of problems or CHC other people had was not relevant, simply that other participants had problems too. For her, support from the group meant she was not alone in her problems. Further, acceptance in the group enabled her to have a voice, where what she thought and said mattered to other people. This experience affected her in a positive way. Jan began to have hope and see herself as being more in control of her problems.

One participant found the group provided an opportunity to socialise with other people.

*Yeah I think everybody was a bit uptight when we first went, but everybody got to know each other, started to talk more... But yeah, after that...everyone was off and away...because you've got to know everybody, and I was quite enjoying going, ...just a social occasion... I certainly enjoyed meeting up with the group, you know, every Tuesday or whatever, yeah... I suppose I got the enjoyment of attending and meeting new people and that sort of thing. **Ralph***

This was significant for Ralph who experienced marked social isolation and spent most days alone. For him, not being alone anymore meant being with people and overcoming his social avoidance tendencies. As he successfully met the challenge of meeting new people, his apprehension around social interaction with the group reduced. While he did not consider his isolation outside of the group, nevertheless, Ralph was able to gain social support from the group as he perceived he was relating to everyone there. This had an effect on his mood which improved on the days he went to the group.

For some participants, experiencing not being alone any more meant they began to look more closely at building potential relationships within their existing social environment. From attending the group, Mary recognised how important it was for her to begin to make connections with people again outside of the group.

*Not quite sure if support is quite the right word. I think, there was possibly one other woman in the group. We might have supported each other a bit but if you are looking at the individuals in the group...Well this is something I've been thinking about and it might be quite nice to catch up again sometime. Yes. Well, you see, anyway, the lady in the group, you know like she was quite nice but I sort of haven't done, what would the word be? Picked up the courage to go and see her... Whereas probably if it was a different sort of a group, just like a coffee club group or a Probus group, I would have done that ...***Mary**

While she reflected on building a friendship with another participant outside of the group, she assumed they did not have enough support for each other or commonality to build a supportive friendship. However, despite this, Mary began to actively consider how to build friendships and where she might encounter friends. Mary's experience of not being alone meant she actively began changing her thinking and her behaviour towards pursuing opportunities where she could potentially receive support.

In summarising the sub-theme *I am not alone*, participants recognised and gained support from both within the group and importantly, some participants increased their social support outside of the group. In their study, Schouten et al. (2011) found similar results and recognised social support provided a normalising environment which allowed participants to gain a sense of belonging and inclusion. Further, they stated psychosocial benefits occurred through members interacting and sharing with other group members, although it is unclear what these benefits were and how they were measured (Schouten et al., 2011). Newbold et al. (2013) found normalising problems

was a key element in their anxiety and depression groups, but this was reported by staff rather than participants. Additionally, social support has been identified as a key therapeutic element in groups and the provision of group support was deemed a desirable therapeutic approach among individuals with CHC (Pagé, Kovacs, & Irvine, 2012).

11.2.2 Others need to try harder.

The interviews revealed participants considered not only how they responded to the therapeutic group, but also their perceptions of how they thought other participants responded to the therapy and contributed to the group. Paquin, Kivlighan, and Drogosz, (2013), report on the effects of the outcomes of other therapy group members on individual members. Further, factors such as group composition and group cohesion can influence group outcome and participant improvement. However, little research has examined the influence between group members on each other and how this relates to other group members' outcome (Paquin et al., 2013).

Some participants were self-reflective and made these observations in comparison to themselves. Other participants' comments were not self-reflective but were observations they made of other participants. However, several participants oversimplified other people's problems and felt their issues were linked to them not trying, either in the group or their personal lives. Participants in this research project talked about others' lack of "effort" and lack of "willingness" to participate in the group and to make personal changes.

One participant's experience of perceiving herself as trying harder than other participants was Mary.

*And I think I could see that I had really worked on some of them, compared to some people. I had really put in the effort, I think... **Mary***

Mary's account contains an emphasis on how she used the therapy components to effect change in her life. Mary's description reflected her in comparison to a group of participants. When she considered other participants, Mary assumed their outward appearance or discourse in the group would indicate improvement. When she thought little had changed in them, it highlighted to her that she needed to ensure she put effort into her own life to ensure positive change occurred. Mary's reflection raises a question about the impact on participants' outcomes or progress that occurs when an individual experiences and sees a lack of effort by others in the group as a burden.

Another participant who tied a person's outcomes to their effort in the group was Fran. She observed that one participant was reticent during periods when the group was encouraged to actively contribute.

*I noticed that the other lady that was there, she never contributed anything to the discussions. I don't know, she was trying to stop smoking, or trying to stop drinking, so she sort of really had huge problems, you know. Which are pretty hard to do, isn't it? But she didn't contribute to the conversations at all.... **Fran***

Fran took the participants' silence as meaning they were not working on their problems. Other possible explanations such as shyness or feeling disconnected from the group could have explained the silence, but Fran did not consider these. Fran was looking for change to occur in the other participant and expected this to be confirmed through the participant sharing their experiences. When no sharing was forthcoming, Fran assumed that the issues the participant faced must have been significant for her not to share. For Fran, her perception of others needing to try harder meant she possibly pathologised the participant's problems in an attempt to explain the lack of

participation. In reality, Fran had no way of knowing whether or not the other participant was experiencing progress.

Tom, on the other hand, did not consider, or reflect on his own effort in the group, or whether the effort he put into therapy had impacted on his life.

*I could really see who were really willing to do something about their own situation or not. **Tom***

Tom assumed he was able to accurately assess other peoples' progress and response to the therapy. He also assumed that more effort was the only requirement participants needed to effect change in their lives.

Ann lacked support from her family. Because she had no choice but to take care of her own home and health, she thought that the other participants should too. Despite her health issues, Ann attempted to "keep on top" of things. When confronted with a participant who expected family to help them, Ann noticed that participant's anger regarding feeling let down by their family.

*One person was elderly and they just-to me you've got to try and help yourself...They wanted everyone else to do things for them and they got rather angry when family didn't offer to do things...And my opinion is they didn't try... **Ann***

Ann considered the participant's problems were a result of a propensity to generally blame others for not supporting them rather than reflecting on what they could do. Ann did not think about the age disparity between herself and the other participant, or the possible differing impacts their similar CHC had on their functioning. Ann did not reflect on her own emotions or the anger she felt towards her own family. Ann lacked insight into her own situation and the difficulties she experienced when she saw

others as having to try harder. It was possible she deflected from scrutinising her problems as it would make her confront the fact she had little support outside the group.

Summarising the sub-theme *others needed to try harder*, the participants made interpersonal assumptions about each other's lack of visible progress in the group and thought it was due to a lack of effort. Paquin et al. (2013) commented that the role of the other group members is important, especially the need for participants to have observed the improvement of others. However, they also state very few studies have examined the mutual influence between group members. Whereas Lau et al. (2010) in their qualitative study report it is important to understand what processes occur in group therapy, especially when a group member may report lowered degrees of change. Social comparison theory (Festinger, 1954) can partially explain why participants report others were not trying (Buunk, & Gibbons, 2007), however, other factors may have been present including the individual's level of participation in the group. Dibb and Yardley (2006) state social comparison occurs in situations of fear and/or uncertainty. Thus, in groups with health issues, participants use comparison to aid in evaluating their situation and concepts regarding their illness. Wills (1981) suggest individuals with low self-esteem tend to make more downward comparisons in order to improve their perception of self enhancement. Currently, research studies considering participants' experiences from a qualitative stance are few in number.

11.2.3 Others might have got more out of the group.

The participants were asked if the groups were effective in helping their situation and whether they were satisfied with the content of the sessions. The participants in their interviews reported not only their own experience but also their perceptions of

other participants' experiences. Generally, in both cases, interviewees considered neither themselves nor other participants gained significant benefits from attending the groups.

This was contrary to statements participants made in other sections of their interviews outlining benefits they had received. The benefits participants commented they received included continued use of therapeutic components such as relaxation techniques, improved mood, increased social support, and improved assertiveness in their relationships with health professionals. A possible reason for participants reporting they had not gained from the group was because a number of participants had received individual psychotherapy prior to attending the groups. Another possible explanation could be their focus on negative outcomes, such as, their health would not improve. VanderZee, Buunk, DeRuiter, Tempelaar and Sanderman (1996) suggested physical and psychological distress can trigger perceived threats to well-being which may cause individuals in a group to attempt to enhance a positive sense of well-being by actively engaging in a downwardly directed social comparison. Thus, participants could evaluate themselves as being better off than others similar to themselves and moreover, under-report therapeutic gains. Thus, participants may have thought other participants were more needy and benefited from the group more than they did.

Interviewees continued to make comparisons between themselves and others in the group. However, participants expressed dissimilar perspectives in trying to make sense of their lack of perceived benefit from attending the group.

Ralph denied any effects his type 2 diabetes was having on his life. He saw others experiencing changes but the impact on him was considered minor in comparison.

I had no idea; I went with an open mind to see what would happen. I don't think I got a great deal...As I say, it's good to listen to people that are worse off than yourself, and see how they're coping, and they would, and how the things were maybe helping them cope, 'cause I mean, you know, as I say, the others may have gotten lots more out of it than I did, you know... **Ralph**

It is possible Ralph used the principle of negative social comparison to make himself feel better and this, in turn, meant he underestimated the impact the group may have had on him. Yet in his account, Ralph experienced a direct contradiction as he experienced being able to listen to others as being helpful. He recognised and learned there were alternative ways of coping and saw the ability to implement changes being modelled by others. For Ralph, despite recognising the benefit of seeing others cope better and of them being helped, he did not incorporate that support into his own experience in a manner he could recognise. Ralph did not consider what aspects of his life may have been a barrier to him acquiring the same benefits others did. He experienced others getting more out of the group because he did not recognise either what he needed, or what he received from the group. Another possible explanation for Ralph's lack of gain was in another statement he made. Ralph links the fact that he did not have clear expectations about what would occur in the groups to his lack of perceived gain from the group. Ralph used his initial lack of awareness about the group in order to make sense of his experience. For Ralph his experience of others getting more out of the group meant he went in with the prospect of receiving help, but it is

possible other barriers and his denial of his diabetes prevented him from recognising how the therapeutic content could apply to him.

Other participants also felt they could have obtained more from the group experience. Ann recognised she had been less forthcoming in the group and commented she lacked trust in other people.

I was just thinking about that, about three, four minutes ago, it was going through my mind. If I had the opportunity I would do it again and perhaps I might be different next time. Hmm. More open, more, yeah, involved, and try and get more out of it. And there's also the point of helping others in the same situation.... Ann

Whilst being interviewed Ann continued to reflect on, and interpret her experience. Ann's focus was on herself in relationship to the group. She recognised her lack of trust had impacted on her experience in a negative way and she felt regret. She appeared to have an understanding that had she participated more fully, the group experience would have helped her. However, Ann also saw by not involving herself more fully, she had denied other participants as well. For Ann, others getting more out of the group meant she had limited herself, and in doing so, she had also limited others from getting more out of the group by not participating fully.

Tom had a very different perspective on how others might have got more out of the group. Tom attended all of the sessions but noticed when other participants missed a session.

But for the others to me it seemed a bit of unfinished business... they hadn't attended and got the full amount of what was there... Tom

Tom directly assumed because a session was missed, other participants must have had fewer gains in therapy. Tom commented on the group size and the low number of participants may have accentuated the absences more in his mind than they did in

reality. What Tom did not realise was diverse aspects of the group and therapy may have affected individuals differently. Tom focused on the other participants, their problems and their reactions to the therapy, rather than reflecting on himself and what attending all the sessions meant for him. From Tom's perspective, other participants may have gained more and solved their issues if they were in attendance for all sessions. Tom saw non-attendance as procrastination or non-adherence and impacted more negatively on an individual as they were not receiving help. He could also have been comparing his problems to others and seeing others as "worse off" and denying help.

The sub-theme of *others might have got more out of the group* highlighted participants' views that they did not believe they received therapeutic benefit from attending the therapeutic group. It is possible their comments were a reflection of the lack of, or view of the group cohesiveness (Hillsdon et al., 2013). Qualitative literature on negative outcomes from therapeutic groups is lacking and seldom reported. In their study of nurses implementing therapeutic group programmes in psychiatric services, O'Donovan, and O'Mahony (2009) report that their participants gained little from their groups for a number of reasons. These included that the content was thought to be not to be relevant to an individual, or the content was basic and repetitive. Also, their participants thought groups should focus on specific problems related to an individual's diagnosis.

11.2.4 Theme summary.

Summarising the theme, *the influence of experiencing group support*, the participants discussed how their perceptions of the group impacted on their experiences. Participants gained the benefit of seeing others with a CHC and realised they were not

alone with their problems. They recognised there were other people like them who understood the difficulties of living with a CHC and this meant the participants in this study were able to normalise their problems. In contrast, the positive benefits of gaining social support and normalising their problems were diminished by the participants thinking more negatively about the group. Schouten et al. (2011) commented their group members benefited from a normalising environment and felt a sense of inclusion and belonging. They report the psychosocial benefits for their group members were strengthened by rapport and effective relationships between the group members. However, in this study, there was a disparity of perceptions. This includes themes that participants were not alone, more effort was needed by group members and others gained more from the group. O'Donovan and O'Mahony (2009) comment that group cohesion was lacking in their group. It is a possible explanation for the divergent experiences of participants in this study. Some were used to being alone and felt apprehensive about joining a group situation.

11.3 Improved Relationships with Health Professionals

Individuals with a CHC may have to deal with contradictory or confusing information from different health providers. At times information they receive regarding their CHC can cause, or add to, levels of distress. Participants were asked what changes had occurred in their lives as a result of attending the group. Most mentioned the communication tool PART (Lorig, et al., 2006), designed to improve social interaction with health providers. It was evident from their responses the impact that attending the group had on their interaction with other health professionals following completion of the group. In this research project, participants readily acknowledged an improvement

in their interactions with health professionals. Further, they related how the group experience helped them gain new insight into how to interact and improve their relationship, and to become more active in managing their health appointments.

Participants actively reflected on how they used specific techniques and suggestions from the group to alter previous behaviours and perceptions during consultations.

Jan had multiple health issues compounded by an accident which exacerbated her low mood and poor physical health. Doctor's visits had become overwhelming for her as she struggled with time pressure to discuss multiple concerns.

It was like going to the doctor and ...and being able to take control of that visit insofar as giving information and what is wrong. Instead of sitting there and thinking 'oh, I've only got ten minutes. How do I get all this across? You know, about writing it down. So that you've got that there, and you can look at it and yes, this is what's wrong. You know, put it there, without having to sit and think 'What did I come here for? I found that good because quite often you go to the doctor and you know you haven't got time ...and you sit and think and 'what did I come here for?... Jan

Jan had been able to share her ideas and was listened to by others in the group. Combined with psycho-education and shared ideas learned in the group, Jan was able to implement these ideas with her doctor. She was able to improve how she spent her time with her doctor. By writing down her issues, Jan gained a sense of self control which improved her self-confidence. Her experience of improved relationships with health professionals meant she was able to articulate her concerns and was able to be "heard."

Ralph had been referred to the group due to difficulty managing type 2 diabetes. At the time of the interview, Ralph was receiving treatment for a noticeable ulcer on his leg.

*It was some advice about preparing for doctor's visits...Oh, well I wasn't going to leave without having, you know, all these x-rays and things. Yeah, things that I wanted to see. I didn't want to be fobbed off. So I went down and I was determined that we would push through with this now and get it looked at... **Ralph***

Ralph mentioned he had left his ulcer untreated for several weeks but after participating in the group decided not to ignore his condition any longer. He reflected on how he had given up easily in the past when he interacted with health professionals. However, in order to have his needs met Ralph was required to undergo a change in how he related to people. He needed to assert himself and overcome his tendencies to avoid difficult interactions and his propensity to engage in negative self-talk that allowed him to be ignored.

Fran also improved her relationship with her health professional by being more assertive.

*Oh, I found what they said about asking your doctor things, that one, being assertive. I found that that was quite good, 'cause even I put that into practice that week, and it worked quite well....I found it useful when I did. It made me ask why. I wanted some, a prescription, wanted to know why I have to keep going each month to renew it, and I didn't know why. And so when I asked, I was told, and given the answer. It sort of gave me a prescription that I could have refilled instead of having to go every month to have that prescription... **Fran***

Fran was able to implement what she had learnt and gained the immediate benefits of reduced costs and reduced need for frequent appointments from using these techniques. Fran reflected on her need to begin to question more about her care rather than accepting the status quo.

However, in contrast to these accounts was Mary's existing relationship with her GP with whom she related she had a good relationship and saw how it had benefited her health.

Well, you know, like my GP's always said "Well, you know your body best when it comes to it." You know, when to take something for a chest infection or pneumonia or whatever. So that's quite good too, having, you know, a good GP... It was just like second nature to me really and I couldn't believe it. Well I had kept pain diaries or different things or sleep diaries. You know, if I had a problem, I tried to make notes and to solve it and I just assumed probably, everybody did that...Mary

Mary was surprised others in the group did not have similar relationships with their GP and did not take responsibility for monitoring and managing symptoms. As a result of recognising skills lacking in other participants, Mary gained insight into her problem solving ability with her health. Further, it made Mary realise how much she had assumed her problems were too difficult to solve. This gave her confidence to implement and solve other issues she had been struggling with such as social isolation.

11.3.1 Theme summary.

Within the theme of *Improved Relationships with Health Professionals* participants spoke of implementing skills they had learnt in the group. By using specific techniques they were able to assertively convey and manage their needs. The relationship between health providers and health care users has been widely researched especially in regards to health care user's outcomes. In their systematic review O'Conner et al. (1999) report decision aiding tools improve communication with health professionals, reduce conflict over medical decisions, aid in the uptake of services and provide better knowledge to patients. Edwards, Elwyn, Smith, Williams, and Thornton (2001) state their participants wanted to contribute meaningfully to discussions and be involved in decision making concerning their care. However, in addition, their participants placed little emphasis on improving actual health outcomes or recognising the importance of medical adherence. Zoffmann and Kirkevold (2012), comment that

their patients' written reflections on their diabetes care aided communication and patients felt more empowered.

11.4 Using the Therapy

The Massey Psychology Health Conditions Service was interested in discovering how participants experienced the group, and the participants were asked about what was helpful for them. Participants were readily able to reflect on the processes and feelings which occurred during the group, rather than explicitly discussing how their moods such as stress, depression or anxiety were affected by the therapy components. But some participants had insight into how the therapy, applied in their situation, would effect positive change. These participants mentioned specific aspects of therapy they found helpful or were continuing to use when interviewed.

The manuals used a biopsychosocial framework to provide a coherent link between the therapy components. The biopsychosocial model was also taught as a specific module. The model recognises that compared to the general population, individuals with a CHC have a higher risk of experiencing factors which influence health and illness including stress, depression, and anxiety (Schinaman, 2005). One participant who found the module explaining this concept particularly helpful was Mary. The biopsychosocial model helped her make sense of the decline over time in her ability to cope, leading to the onset of depression and increased social isolation.

Well I think the biopsychosocial model helped me because, like, when I was first sick, my mind, I seemed to be able to keep it quite positive. Whereas, yeah, somehow, I wasn't quite able to do that... Mary

Mary had thought of her physical illness and her mental health as separate entities. Despite being proactive and managing her physical health, Mary had not been

as capable, in her mind, of managing her mood. She reflected on how the amount of effort she had spent caring for herself physically had compromised her resilience. Gaining insight into how she functioned from a wider perspective enabled Mary to fully understand her health. Importantly for Mary it opened up a whole new avenue of possible action she could take to improve her well-being.

The manuals suggested to the participants that part of the biopsychosocial model, including social functioning and the social environment, impact on an individual's well-being. Thus, the group participants' identification of changes in social support, improved social integration (participation in the community) and increased social contact were important. In general, when considering the social support components of the sessions, most participants' primary focus was on their relationship with others in the group and their sense of how they as an individual compared to the others. However, Mary was able to gain insight from her knowledge of the biopsychosocial model and as she reflected on it, took specific action to increase her social support and networks she had neglected over the last three years.

*People are noticing, you know, like, I don't know when I last smiled but I am... You know, like even going to Ladies Group, people have just said "Oh, you look so great" because I haven't really made it much for about the last three years... **Mary***

And

*...So anyway, this friend and I meet up regularly on a Wednesday now and it's really nice, you know... **Mary***

Mary understood that, for her well-being she needed to have people in her life to rebuild her resilience and to positively encourage her as she dealt with her physical health.

When studying the data, a noteworthy observation was the varying levels of self-reflection and insight different participants had in response to the group processes. An example of differing levels of insight when implementing the therapy was seen when participants discussed what they found helpful in the sessions. When interviewed, most participants recalled the relaxation and biofeedback therapy as being helpful and stated they were either using the relaxation techniques or the relaxation CD. In another health setting, Ann had been taught how to use the diaphragmatic breathing relaxation technique to reduce pain, improve her depression and help her heart functioning.

... I did like that relaxation programme. The breathing and depression symptoms...It was something I'd been told about but it wasn't explained properly. But (the clinicians), educated me properly in that. And I found that a great pain release. Standing at the sink, type thing, watching TV, I will do it then, occasionally, not regularly but I'll sort of sit there and think 'Oh yeah, I could be doing that now'... Ann

Ann's self-reflection on why she had not used the technique was that she had not been taught properly. Biofeedback used during the group also served as further relaxation reinforcement for Ann so she could see and experience her ability to have control over her body's functioning. However, despite noticing and experiencing the benefit of relaxation during the group, Ann could not identify why she remained ambivalent about using relaxation to help her CHC and only used the technique sporadically. It is possible Ann may have minimised the benefit of relaxation. When she reflected on the magnitude of her CHC she could have felt overwhelmed regarding the effort she could make to improve her CHC. Jan also had limited insight into the benefit of relaxation therapy, but recognised implementing activities learned in the group would help her.

I also have a relaxation period between ½ to 1 hour daily. So I have achieved some helpful resources from attending the psychology group at Massey... Jan

By using the relaxation technique, Jan began to reflect on how her action and behaviour change were beginning to impact on her mood in a positive way, although she remained unaware of why it was helping her and what aspect of her health it was addressing. Other participants developed a deeper level of personal insight and were aware the technique positively impacted on them physically and mentally. Tom noticed the technique improved his sleep but also helped him with problematic thinking.

Those relaxation exercises...I am still doing them. Especially like before going to bed. I used to turn around in bed and speculate...the progressive muscle relaxation helps. Yeah and you go to bed and in 5-10 minutes you are gone... Tom

As he reflected on using the technique, Tom had a sense that while he was relaxing, his problems disappeared and he gained relief. Importantly, Tom's insight linked his action with his improvement and he noticed his improvement addressed his issues.

While participants recognised individual aspects of therapy were helpful, one participant recognised the impact of the content of the therapeutic group and reflected overall how it helped her. Jan's insight when she was interviewed was on the content she had received and the behaviour changes she applied as a result.

Much has changed since then for me personally. I did not realise how much the depression had consumed me, which I am now dealing with. I am now walking, not long distances, short and regular, and accepting the fact I am better doing that than none at all. I also have a relaxation period between ½ to 1 hour daily and I have had a visit to my Doctor to put into practice what I learnt during the course. So I have achieved some helpful resources from attending the psychology group at Massey. I am the first to admit I still have a lot to achieve but I am feeling so much

improved and I am also attending a course for healthy living with chronic health conditions. So I am trying to deal with my problems... Jan

What Jan remained unaware of, however, was the impact of the group process and the input other participants had given her, increasing her confidence and improving her self-esteem. Jan was able to become more proactive and sought other programmes to reinforce changes she made by attending the group.

Despite participants commenting they did not get much out of attending the group, participants did implement and continue to use therapeutic elements after the group had finished. Nelson et al. (2013) found their angina participants were mixed in their views about implementing effective eating behaviour change after completion of their group. But their participants were more likely to exercise and half of their participants used their relaxation CD (Nelson et al., 2013).

11.4.1 Denial of illness.

While participants were able to identify aspects of the group process or content that was helpful, other participants struggled to find examples of what helped them. Feelings of stress and depression have been linked to accounts of denial of illness severity in individuals managing their illness. Denial of their illness severity also occurred among participants in this study, and it is a possible explanation for self-reported lack of progress. Jones, Crabb, Turnbull, and Oxlad (2014) report participants who experience denial of an illness have problems with self-management of their illness and a higher likelihood of failing to carry out recommended treatment and advice.

Ralph, despite experiencing obvious symptoms of his CHC, had delayed seeking treatment for a diabetic ulcer. Further, he acknowledged he was sporadic with his medication and did not monitor his glucose levels.

I'm probably the classic example of, I know what I should be doing, and I'm not entirely following the plot, you know. The doctors and the nurses and the people tell you that this is what you should be doing. And, yeah, and a lot of people totally ignore it. I don't totally ignore it, I've made a bit of a change in my eating habits. But yeah I know I should eat healthily, lose weight, stop smoking, get some more exercise. They keep hammering me about the exercise, yeah. I don't know, I think people need a reason... **Ralph**

Ralph reflected on his knowledge of illness management and how he deviated from good care of his illness. His reflections on himself led him to feeling “hammered,” disapproved of by others, remorseful and in emotional pain. His avoidance of treatment for his ulcer meant he could avoid these negative emotions. Being non-compliant was more emotionally comfortable for him. Ralph lists multiple areas where he is not complying and vindicates this by noticing others who also do not comply. He fails to consider people who do comply and manage their symptoms well, as this maintains his avoidance of difficult emotions.

Another individual who struggled with denial was Ann. However, instead of internalising her denial like Ralph, Ann's denial was focused externally towards her family.

I mean even with smoking I get frowned at. Boxing Day I had a few big wines with a mate that came down from Auckland. But it was good, I was in control, I think, and that would be the first alcoholic drink I've had for a while. Sorry, I had two mouthfuls on Christmas day of beer, but it would be the first time I've really got into the drink for a few, quite some months. Hence I enjoyed it. But the family's always sort of watching saying “You shouldn't be doing that”, “You shouldn't be doing this”... like they're all waiting for me to “kark it” and I can't relax around them because they're just watching... **Ann**

Ann's serious chronic heart condition had required multiple surgeries yet Ann did not consider her alcohol consumption or smoking had impacted on her health. Her denial meant she experienced problematic interactions with her family. Ann could not accept her family were concerned and felt that they were not truly caring, or meeting her emotional needs as a parent, or her practical need for help around her home. Their scrutiny around her drinking and smoking left Ann feeling neglected and rejected. These feelings in turn affected her ability to trust her family to help her. Ann was unable to consider how these emotional needs may have led to her smoking and alcohol use.

Another participant who minimised her difficulties was Fran. Fran was experiencing nocturnal panic attacks and increased levels of anxiety. She continued to have difficulty, despite using a nightlight, and questioned why she had been referred to the group.

*I thought "I don't know why I'm really here, because I've sorted the problems now", and also I had a night, put a nightlight on, and I found that helped me a lot...When the girls did the programme on the computer with the gardens and things (biofeedback exercises), everybody else could do it but me. And I thought I was fairly relaxed, but obviously I'm not as relaxed as I thought I was. And since I've come home I find myself concentrating on trying to relax, sometimes I am a bit uptight. I didn't realise I was doing that. I thought I was not uptight, but I obviously was...**Fran***

Fran's denial enabled her to maintain a false sense of mental wellness after she had experienced a potentially life threatening severe health setback. Had she reflected on her anxiety as a result of her near death experience, Fran could have been overwhelmed, further reducing her ability to cope with her sickness.

Participants in this study minimised their health concerns and the impact it had on their lives. There are similarities in the finding of this study and that of other

research. Hillsdon et al. (2013) found in their study on cardiac rehabilitation, participants continued undesirable health behaviours. Other research has also highlighted participants who avoided accepting their illness consequences. Brink (2009) considered adaptation and coping with an illness, and identified how myocardial infarction participants attempted to maintain prior event tasks and performances, despite known risk to their health. Denial has been identified as a common strategy in a number of CHCs including asthma (Kligler, McKee, Sackett, Levenson, Kenny, & Karasz, 2012). Tod, Read, Lacey and Abbott (2001) report participants who avoided medical treatment and advice were motivated by fear and anger related to having an illness, and the impact it had on their lives. On the other hand, Jones et al. (2014) found denial in their diabetes study consisted of participants feeling overwhelmed and stressed. This led to participants' lack of self-management and avoidance of responsibility in caring for themselves. In addition, denial caused inaction and inhibited change in diabetes care (Jones et al., 2014). Gibson and Watkins (2012) however, found even if their participants recognised the serious nature and implications of their condition, they either ignored or minimised the consequences.

The participants in this study had serious health issues which were unlikely to improve or abate. In their comments, it appears denial was used as a coping strategy to help participants avoid looking introspectively at themselves and accurately assessing their difficulties. It raises the question regarding what level of insight they had into their illness and whether this may have affected treatment receptivity in the therapeutic groups.

11.4.2 Summary.

Participants' therapeutic group experiences were considered in this chapter. The themes identified in the participants' responses included the *initial experiences of joining the group, influence of experiencing group support. Improved relationships with health professionals and using the therapy.* By attending, the group participants obtained valuable social support enabling them to normalise their problems. However, social comparison was also evident, leading to perceptions that their health was better than others and therefore a lack of cohesiveness in the group. It is possible this attitude reflected a negative emotional state which would have been present at the beginning of the groups, given that their reason for referral was based on psychological difficulties in managing their condition. However, while social comparison may have an impact on how participants evaluate their health, research is not clear on how this may affect their overall psychological levels of distress, anxiety and depression.

Despite social comparison being pervasive in the participants' accounts, universal learning and implementing of skills and techniques were key positive outcomes for the participants. Participants applied a number of techniques into their lives designed to improve their quality of life and health care management. In particular, participants used the PART communication tool (Lorig et al., 2006) during appointments with their health professionals and found they were able to assert their needs more effectively.

CHAPTER 12 DISCUSSION

This chapter discusses the current study findings. It examined the experiences of the clients and clinicians who participated in the manualised group treatment programme of the Massey HCPS for clients coping with psychological distress, as a result of living with a CHC. The study utilised both quantitative and qualitative methods to explore six participants' experiences of attending the group and also three clinicians' experiences of facilitating the groups. The manualised group treatment programme used a biopsychosocial framework with an eclectic therapy approach to improve participants' quality of life and reduce levels of distress. As assessed by psychometric inventories, levels of quality of life and distress remained unchanged, although valuable insights were identified in the qualitative results. As found in other CHC research, participants in this study reported initial apprehension. But they also increased their awareness that they were not isolated and alone, and that others shared their difficulties. Further, they reported their communication with health professionals improved. An unexpected finding was that participants used downward social comparisons (Festinger, 1954) to subjectively judge their well-being as being better off than others by comparing themselves to others they perceived as having more severe problems (Buunk et al., 1990; Gorawara-Bhat et al., 2008). The clinicians remained focused on what they thought the individual needs of the participants were as they learned new skills around becoming a group facilitator and managing groups. Despite limitations discussed further in this chapter, both participants and clinicians reported the therapeutic group was helpful, and suitable for use in a group setting for individuals with difficulty living with a CHC. Along with the study's limitations, and recommendations and areas for future

research, the implications this study has for international and New Zealand clinical practice are discussed.

12.1 Major Findings

The aim of this study was to determine whether the manualised group treatment programme was effective in improving quality of life and reducing distress in clients with a CHC. The study also explored the clinicians' and participants' experiences of the groups. Answering the initial research question also provided direction for further investigation into group treatment for CHCs. It was important to examine what experiences helped or may have been unhelpful for the participants. The purpose was not to compare the pilot manual with the main well-being manual but to provide a manual which could be used by the HCPS.

12.1.1 Clinicians

The clinicians were involved in the research project in several ways. Firstly, prior to the groups, they provided feedback on the development of the pilot and main well-being manuals. Next, the clinicians facilitated the groups and implemented the manual. Lastly, the clinicians were also interviewed and asked for their observations and evaluation of the manualised group treatment programme. The clinicians were asked questions about how the participants responded to the therapy and their experience facilitating the groups. The themes that emerged from the clinicians as they considered their roles and how they managed the groups included *becoming a group facilitator, preparing for the sessions, managing the groups and evaluating the sessions*.

Kendall and Grove (1988) comment that by using observation and anecdotal evidence such as participants' comments, meaningful change can be assessed. It was evident from their responses that the clinicians evaluated the sessions in this manner. They were aware that their evaluation was not a formal process, but it was valuable nevertheless as it impacted directly on participant care.

Clinicians debriefed directly after each session and evaluated the participants' responses and planned for the next session. They thought about how participants responded to content, how the session may have benefited the client, and what needed to occur next for each clients' or the group's treatment. They continued to formulate treatment and consider participants' individual needs. The collaborative approach which developed naturally amongst the clinicians as they worked together was similar in manner to family therapy research which uses reflection and feedback from other members of the group or co-facilitators (Harrawood et al., 2011). Yalom (2002) proposes that observing therapy in practice allows meaningful examination of the clinical process to occur. Also Helmeke and Prouty (2001) contend experiential observation increases empathy and sensitivity to clients' experiences.

Feedback from the clinicians regarding the effectiveness of the manualised programme was positive despite participants displaying little change on the psychometric inventories. The clinicians recognised that the psychometric inventories were not necessarily capturing what was occurring in the groups at the time.

When considering the manuals, the clinicians were in agreement that the objectives and layout of the manual, the instructions and therapeutic components were clear, easy to follow and aided in managing the group and sessions. Clinicians reported

they were comfortable, and confident they would manage the groups and the sessions based on the structure of the manualised group treatment programme. From feedback to the researcher, there appeared to be good-will from the clinicians towards the programme. Further, when considering participants' responses to the groups, the clinicians considered they were engaged with the therapeutic content, the groups were cohesive and that the participants benefited from attending the sessions. They reported the manualised group treatment programme achieved face validity and was fit for its purpose as a therapeutic tool the HCPS could use for future groups to help clients deal with consequences of a CHC.

The clinicians in this study were not experienced group facilitators and this was the first time they were implementing the manuals. The clinicians recognised their beliefs about therapeutic groups effectiveness changed from considering one on one treatment as the optimum method for therapy delivery. However, their core belief remained focused on meeting the individual client needs. Initially, they perceived the gold standard for treatment was individual therapy but came to regard groups as being a relevant treatment modality. As described in Hopkins and Irvine (2012) the clinicians became more flexible in their thinking as they learned new skills and faced dilemmas. These dilemmas included managing group interactions and challenges in trying to meet client needs through the group medium. However, unlike Johansson et al. (2014) the clinicians in this study did not report a change in their role from being the expert leading the group, to a role which activates participants and encourages them to share their experiences. Yalom and Leszcz (2005) suggest leadership style improves and changes with experience.

12.1.2 Outcome measures.

The manuals in this study were designed to be administered by trained clinicians to bring about therapeutic change for group participants with a range of heterogeneous CHCs. Because well-researched and proven interventions were used, it was expected that group participants would show improvement and change would be evident on these inventories. Some of the participants had received individual therapy prior to the groups. The pilot group had four participants and the main well-being group had five participants. Participant numbers were lower than the optimum of around eight suggested by research. In general, the participants' pre-treatment scores compared to their post treatment levels of functioning remained stable and indicated no change on the quality of life and distress measures. It is possible larger group sizes and more participants could have produced meaningful results enabling consideration of treatment effectiveness based on inferential analysis. Nevertheless, in appraising the manualised group treatment programme it is important to consider possible reasons why this result occurred. For instance, group sizes were smaller than research recommends, some participants had previous one on one therapy for up to one year and the clinicians were novice group facilitators. These are discussed further in the study's limitations. Another possible explanation is the difficulty of transferring research into a naturalistic setting. The availability of research on evidence based interventions over recent decades has grown. However, implementing those programmes into innovative real world practice and using these tools to achieve effective outcomes has not been widely researched (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). Nelson, Cordray, Hulleman,

Darrow and Sommer (2012) report that effectiveness is likely to be reduced when researched interventions are implemented due to the need to adapt to a real world setting and client needs.

12.1.3 Participants.

A mixed methods approach used qualitative data to assess the manualised group treatment programme. The participants did not mention quality of life or distress constructs during their interviews. This was not unexpected as questions were purposely open-ended and direct questions on these topics were not asked, in order to allow factors important to the participants to come to the fore.

Four major themes were identified in this study. The two themes *the Influence of Experiencing Group Support* and *Improved Relationships With Health Professionals* report similar positive impacts on CHC care that other research has identified and are discussed first. Next, the theme *Using the Therapy* is examined and considered in terms of continued use of therapy tools. Lastly, the theme *Experiences of Joining the Group* is discussed.

12.1.3.1 *The influence of experiencing group support.*

The theme *the Influence of Experiencing Group Support* is a common finding in group research. Social isolation can contribute to negative health outcomes and within a group context, receiving or perceiving social support from others with similar difficulties can help reduce the negative impact of a CHC (Eisenberger, 2013). As with Schouten et al. (2011), participants in this study commented that they benefited from a normalising environment and felt a sense of not being alone with their illness. This had

a twofold effect. Firstly, they recognised others had what appeared to be more significant problems than they did and this helped them place their own illness into a more manageable perspective. Secondly, by being with other people with a CHC, participants felt accepted and were able to relate to others who understood some of the difficulties they faced managing their CHC. Mallinckrodt (1989) report social support in groups is important and contributes to the effectiveness of group processes. They report direct advice from people who have experienced the same stressor is beneficial, but positive social support outside of the group has a more significant impact.

When evaluating the effectiveness of the manualised group treatment programme, it was evident from their responses that normalising their problems with a CHC was a significant help to some of the participants. It enabled them to recognise their situation was not unique and they were able to gain valuable insight and benefit from the experience of others. Yalom and Leszcz (2005) consider this the principle of universality, which is a major curative factor that occurs in groups.

12.1.3.2 Improved relationships with health professionals.

Many clients of the HCPS have significant comorbid and complex CHCs which require a number of appointments with multiple health care services. One of the numbers of factors affecting treatment adherence is difficulty communicating with health professionals. Participants spoke of implementing skills they had learned in the group and as with Edwards et al. (2001), found they contributed more meaningfully to communication with their health care professionals during appointments. O'Conner et al. (1999) reports using decision aids and communication tools designed to increase participation in medical care decisions increases treatment uptake and adherence.

Improved health care interactions are an important finding when considering the evaluation of the effectiveness of the manualised group treatment programme.

Participants were empowered and reported they took increased action to have their needs met when seeking treatment. One participant received treatment for a diabetic ulcer that they had previously ignored.

12.1.3.3 *Using the therapy.*

The participants commented directly that they had not achieved significant gains from attending the group. Additionally, it is unclear how important participants felt it was to work actively towards practicing and implementing the skills learned in the group into their lives. However, this was in direct contrast to other comments they made and their reported continued use of therapeutic tools they had acquired in the therapeutic groups. This is important when considering the evaluation of the manualised group treatment programme as it provides direct observable evidence of behaviour modification, which could potentially result in psychological change. Further, it suggests that the participants' experiences or self-reflections were based on their interpretations of themselves or specific individuals in the group, rather than the therapy content or the group process as a whole.

Of the therapeutic tools used in the manual, participants were able to name and give details of how they were using specific components. They mentioned improving communication with health professionals (P.A.R.T; Lorig et al., 2006), relaxation therapy, and finding ways of increasing their social support. Of note, the participants also commented about the psychoeducation regarding the biopsychosocial model. The model and its use in framing therapy in the therapeutic groups helped participants to

understand how their illnesses were affected by psychosocial, as well as biological factors. This understanding gave them several benefits. They were able to use the framework to make sense of their health, possibly allowing the participants to share a similar understanding of their health needs, to that of their health professionals. They also used the framework to improve specific aspects of their lives by ensuring they were caring for their mental and social well-being. This included increasing their social support within both their families and the wider community, as well as using the relaxation skills they had acquired on a regular basis.

Attendance rates for the groups were high. Another measure of success for the groups was the fact there were no drop outs. All of the participants attended at least four sessions with most cases attending all of the sessions. This was in spite of the fact that this group of people were physically unwell with debilitating illnesses or CHCs.

12.1.3.4 Initial experiences of joining the group.

In terms of evaluating the manualised group treatment programme, the participants' experiences, such as their perceptions and beliefs regarding treatment effectiveness, their ability to build rapport with the clinicians and other group members, and their ability to engage with therapy were all relevant. It was important to understand what participants experienced when they joined the groups as adverse experiences can affect dropout rates, group cohesion and treatment outcomes (Burlingame et al., 2001). Participants in this study had similar reactions to those reported in other studies. In the sub-theme *Feeling Apprehensive* participants appeared concerned about who else would be attending, what they would be like and what would be the general social environment of the group. Newbold et al. (2013) report apprehension can occur as a result of

treatment fear and can stem from fears caused by expectations about the kind of professional help individuals will receive, as well as the fear of having to discuss uncomfortable topics, and of experiencing strong emotions. In the sub-theme *What It Was Really Like*, participants reported they were concerned about how others perceived them, and that they lacked commonality with each other. Once the therapeutic groups began, the sub-theme of being *Better Off Than Others* emerged. This finding was an unexpected result in this study. The inference is that it suggests social comparison occurred within the early stages of the therapeutic groups. As they sought to find commonality within the group, participants may have used downward social comparison as a way to help them feel better about themselves. However, participants may have formed cognitions which were not accurate about the serious nature of their problems. Further, they may have felt they did not need the intervention as much as others in the groups, as their problems were not as serious.

In terms of evaluating the manualised group treatment programme, the theme of the *Initial Experiences Of Joining The Group* may explain why participants did not show change on their psychometric scores. Downward social comparisons may have influenced participants' coping strategies and illness perceptions such as readiness to change and outcome expectancies. Group preparedness and readiness to change were not formally assessed prior to participants joining the groups. This, along with the fact that several participants had already received prior individual therapy, may have been a significant contributing factor to the participants' stable self reports.

With the theme *The Influence Of Experiencing Group Support* and the sub-theme *Feeling Apprehensive* it is possible to tentatively link these to the wider field of

group processes and group therapeutic factors. These are outlined further in the following section.

12.1.4 Group structure, process, and therapeutic factors.

12.1.4.1 *Group structure.*

The manualised group treatment programme used a closed, structured format with weekly sessions of two hours duration. Neither the participants nor the clinicians commented on these aspects of the format. The clinicians commented that the objectives, and the outline of the sessions, worked well from their perspective. The small size of the groups had an impact on some participants. They commented they would have preferred a larger group. Garvin (1981) identified small group size of between four to eight members brought pressure on participants to participate. He commented small groups of this size created an intimacy some members felt threatened by. However, the clinicians found having a small group size meant the groups were easier to facilitate than they anticipated. They did not have to manage a large number of group relationships or intervene in group conflicts. As the clinicians had seen some of the participants for individual sessions prior to the groups, the clinicians commented they felt they had already developed a good therapeutic relationship with several clients.

12.1.4.2 *Group cohesion.*

A decision was made not to focus on or assess group process, stages of change and therapeutic factors. Nevertheless, it is possible to link therapeutic processes from the clinicians' narrative which they may have observed, but not necessarily identified or

assessed as occurring, based on Yalom and Leszcz (2005) curative therapeutic processes.

In general, when the clinicians discussed their experiences they were aware of the group's cohesion. The themes *Managing the Group* and the sub-themes *Getting People Involved*, *Reining People In* and *Governing the Sessions* discuss the way the clinicians perceived group cohesion, and the manner in which they created a therapeutic environment for their clients. Neither the clinicians nor participants reported issues with conflict or intergroup difficulties. As a result no-one dropped out of the group and session attendance was high.

However, group cohesion from the participants' perspective differed from the clinician responses. The social comparisons, impressions and judgments they had of each other affected the relationships they formed within the therapeutic group. In the theme *The Influence Of Experiencing Group Support* and the sub-theme *I Am Not Alone* participants saw the value of the social support they received in the group. Yet some barriers existed which meant forming more meaningful friendships within the group and outside the group did not occur.

The clinicians based their opinion of group cohesion on behavioural observations of the participants' interactions with each other, and considered the groups were cohesive and worked well together. On the other hand, participants based group cohesion on their personal cognitive processes and impressions of other members, and not on how they related to each other.

12.1.4.3 *Group stages, processes and therapeutic change.*

Aside from group cohesion and participant characteristics, group structure, stages and processes were not to the fore of the clinicians' thinking. This is not surprising given they were managing a new intervention and they were not experienced group facilitators. According to Yalom and Leszcz (2005) therapeutic outcomes improve when more curative factors are present. Although they were not necessarily aware of this, both the participants and clinicians recounted instances in their accounts which described some of the curative therapeutic factors. In their reports the clinicians observed instances of the installation of hope, universality, imparting information, development of socialising techniques, altruism and group cohesiveness. Most of these factors according to Schneider et al. (2014) occur at the beginning stages of a group process. Thus, it is possible the more in-depth or advanced stages of curative therapeutic processes may not have occurred in these groups. The clinicians in this study appeared to focus on the first tier of Yalom and Leszcz (2005) two tier approach for facilitators to bring effective change in groups. They attended to the immediate events and interrelationships present in the sessions. The clinicians were not asked and did not comment on whether they were aware of, or attended to, the next tier which is a self-reflective examination process of the here-and-now experience which had occurred.

12.2 Study Limitations.

The findings in this report are subject to several limitations. Difficulty with recruitment and the referral processes for the groups had a major impact on group size and the results of this study. There were several issues related specifically to this one limitation.

Firstly, the pilot group had four participants while the main well-being group had only five participants. Schneider-Corey et al. (2014) state eight members is an ideal number of participants for a group and Burlingame, et al. (2011), comments that groups with such a small number of participants, similar in size to the groups in this study, impact negatively on group cohesion. They found that cohesion influences how members accomplish a given task or goal, and indicates what emotional support members feel the group experience affords. Their literature review of group cohesion involved investigating how cohesion has been defined in studies, and included both qualitative analysis and meta analytic reviews. In identifying cohesive moderators and mediators in group therapy, their study included five other published meta-analyses. However, their study was limited by the heterogeneous nature of how cohesion was measured and defined in the literature. Meta analytic studies of this nature are considered as providing strong and robust evidence that support their results.

Secondly, new referrals to the HCPS were offered either individual therapy or the opportunity to join the therapeutic groups. Unsurprisingly, given that therapeutic groups are relatively rare in New Zealand; individual therapy was the preferred choice of most people referred to the clinic. Thirdly, another possible reason for the reluctance to join the groups was identified by one of the group participants. They commented that the health professional that initially referred them to the group was unable to tell them any pertinent information regarding the groups. This may have compounded some of the participants' sense of a lack of preparedness for the group experience, as well as increased levels of apprehension at joining a group programme. Participants were unsure how the group would benefit them and what attendance entailed. Lastly, another

problem with consistent recruitment was due to the referral rates to the HCPS of potential group participants being inconsistent. Thus, obtaining an effective group size in the same location at a given time was problematic. Willing potential participants could not be left without therapy while recruitment for further group participants continued intermittently, nor could they be expected to travel long distances to attend a group in another area. Therefore, in order to facilitate the programme, participants who were currently receiving individual therapy were approached by the HCPS clinicians to join the group. However, existing research suggests combining treatments in this manner reduces treatment effects (Bernard et al., 2008). Bernard et al (2008) is the clinical guidelines for group therapy produced by the American Group Psychotherapy Association. It considered both empirical research and clinical and theoretical literature in the development of its guidelines. Thirdly, another possible reason for the reluctance to join the groups was identified by one of the group participants. They commented that the health professional that initially referred them to the group was unable to tell them any pertinent information regarding the groups. This may have compounded some of the participants' sense of a lack of preparedness for the group experience, as well as increased levels of apprehension at joining a group programme. Participants were unsure how the group would benefit them and what attendance entailed. Lastly, another problem with consistent recruitment was due to the referral rates to the HCPS of potential group participants being inconsistent. Thus, obtaining an effective group size in the same location at a given time was problematic. Willing potential participants could not be left without therapy while recruitment for further group participants continued intermittently, nor could they be expected to travel long distances to attend a

group in another area. Therefore, in order to facilitate the programme, participants who were currently receiving individual therapy were approached by the HCPS clinicians to join the group. However, existing research suggests combining treatments in this manner reduces treatment effects (Bernard et al., 2008; Rosser, Erskine & Crino, 2004).

Another limitation of this study was that clinicians' treatment fidelity was not formally assessed or monitored. Thus, it is not possible to accurately conclude or validate the effectiveness of the manualised group treatment programme in terms of treatment fidelity. Although the manuals were used, the paramount consideration was meeting the complex needs of the participants. The flexibility of administration of the manual ensured the session format did not impose rigid protocols and result in unethical treatment, as some strategies may have had better effectiveness for some conditions. Further, it should be realised the practitioners sought to implement a manual that consists of research-based interventions supported by existing research studies, but the application of these must be suited to the needs of the clients concerned.

An additional limitation was that the study did not have long-term follow-up with either psychometrics tests or interviews to assess long-term change. Therefore, it was unclear what long-term impact illnesses and the severity of illnesses may have had on participants and their long-term response to therapy.

12.3 Recommendations

12.3.1 Recommendations for the Health Conditions Psychology Service.

Furman et al. (2014) suggest when evaluating a treatment, broad questions regarding the strengths and weaknesses of a programme should be asked to enable

programme improvement and implementation. Results from the clinicians' interviews and this study have highlighted several areas for improvement for the HCPS and clinicians facilitating the programme.

Despite being experienced clinicians, none of the facilitators had received any targeted and specialised group training. Clinicians commented they would have benefited from training had it been readily available. This may aid clinicians as they gain experience in helping groups to engage and benefit from therapeutic factors such as those outlined by Yalom and Leszcz (2005). Currently, group facilitation training is difficult to locate and it may require the HCPS developing its own specialist group training programme.

In their already busy practice, the clinicians did not have sufficient extra time to specifically learn and practice implementing some of the unfamiliar therapeutic interventions used in the manual. However, they reported using the manual was beneficial for novice group facilitators or clinicians who may require more directive instructions than an experienced clinician, or one more familiar with the treatment components.

In order for group-based treatment benefits to occur on a regular basis in the HCPS, recruitment issues need to be addressed. Referrers require further information and education on the purpose of the groups, therapeutic components, and the value and beneficial outcomes of the therapeutic groups for their clients and patients.

Unfortunately, it appeared referrers were unable to meet the participant needs for information and to allay possible apprehension participants may have experienced prior to the groups. Also, extra time was required by the clinicians to recruit participants,

prepare the group venue, prepare for the sessions and coordinate and plan co-facilitation of the groups. It is recommended that managing the groups becomes a specialist role assigned to a team member within the HCPS, and for systems such as specialised consent forms be developed to support and facilitate the organisation of the group.

12.3.2 Recommendations for future research.

In future research it is recommended that multisite recruitment and administration of the group based intervention occur. While face validity for the programme was achieved in this study, further supporting evidence of the programme's effectiveness is required. As part of the implementation of the programme, and to increase validity for future research, it is recommended that clinical and research processes be developed. These include initial clinical assessments which consider and assess participants' readiness for a therapeutic group and readiness for change. Also, treatment fidelity across the groups should be developed by standardizing protocols to ensure generalisability of results. This study did not assess session content and outcomes other than in an explorative manner. Future studies could consider whether some sessions are more suited to certain CHCs or bring about more change than other sessions. Other outcome measures could also be considered which measure social support, increased coping, or programme satisfaction.

In addition to further research regarding a therapeutic group, this study also identified areas where future group research could occur. Limited research exists which considers clinicians' experiences facilitating groups from their unique perspective. This especially includes longitudinal studies considering how a clinician develops their experience from being a novice to an experienced group facilitator. Yalom and Leszcz

(2005) suggest experienced facilitators produce more beneficial therapeutic outcomes but what specific skills and how these skills develop has not been clearly elucidated in the research. Understanding how clinicians improve their practice could have important ramifications for therapeutic groups.

According to Crowe and Grenyer (2008) few studies examine group climate and treatment outcomes. A significant finding of this study was the level of social comparison which occurred, and in particular, the impact this had on participants' perceptions regarding their own health. Little research studying the effect of social comparison as a defense mechanism and possible mediating factor within CHC group research exists. Further research elucidating these aspects could aid treating participants who have difficulty accepting their illness diagnosis, illness severity, or treatment.

12.4 Conclusion

The aim of the present study was to develop and evaluate a manualised group treatment programme to deal with the psychological consequences of having an ongoing CHC, as well as providing information to aid the Health Conditions Psychology Service at Massey University in its decision-making processes.

The results of this study suggest that face validity for the programme was established based on a thematic analysis of both clinicians' and participants' experiences. Participants' quality of life and distress as measured by the Hospital Anxiety and Depression Scale, Outcome Rating Scale and Short Form-12 remained stable. This result is not unexpected given that the study was considerably limited by a low number of participants in the groups and several participants who had previous individual therapy. In addition, by their very nature psychometric tools are narrow and

specific in scope. Furthermore, other factors were present in the study in which psychometric measures may have shown more robust results, such as an increase in social support, or evidence of improved communication with health professionals.

In contrast the qualitative results from the thematic analysis of interviews provided insight into how the groups unfolded. The value of studies with a qualitative component is that they bring insight into the personal experiences of the participants. They also shed light on other areas of change not identified through psychometric measurement tools, such as behavioural change. In this case, low group numbers may have affected group processes and how participants regarded each other and their illness. While some group curative therapeutic factors were observed by the clinicians, participants used downward social comparisons as a coping strategy. This had the effect of them possibly underestimating the severity of their CHC. It is also possible participants may not have reached a level of personal insight into the benefits their own behaviour change was having on their lives. Further, they may have underestimated the implications of their illnesses because they may not have had the psychological resources to cope with the reality of potential mortality as a result of their CHC. Nevertheless, participants reported behavioural change, and were implementing therapy tools in an ongoing fashion. Importantly, they reported an improvement in communicating with health professionals and commented they were able to address their health needs more effectively during appointments.

Additionally, the closed structure of the group and arrangement of the manual aided both the inexperienced group clinicians and the participants. Clinicians were able to use the manual's structure in a beneficial way to facilitate group interactions. This in

turn helped the participants gain social support from the groups, and assisted them in problem solving their situations. Both the clinicians and participants recognised participants were better off at the end of the therapeutic groups than they were prior to the groups. However, despite the benefits of the group and manualised treatment programme, it must be remembered that participants will still have to contend with the issues involved with living with a long term CHC and the fact that their CHC is unlikely to improve.

This study has added to the limited literature existing in New Zealand for group interventions with heterogeneous CHCs for an equally heterogeneous population in a naturalistic clinical setting. It has also added to the small number of international psychological research studies which have explored both clinicians' and participants' experiences of manualised group treatment programme for CHCs.

This study also highlights some of the difficulties implementing evidence based efficacious therapies as they are applied and practiced in a naturalistic clinical setting. The HCPS aspired to develop a manualised group treatment programme for use in its rapidly expanding Service. The therapeutic groups were designed to be run in a flexible manner with participant needs remaining to the fore. According to the clinicians who facilitated the groups, the manual provided a coherent treatment with clear goals and objectives in each session which were able to be translated readily into therapy.

The use of treatment manuals plays an important role in clinical practice. It allows for the transfer of research components into practice while still ensuring accuracy towards the researched item is maintained. It allows for research in

transferring findings from one site to multisite administrations, with multiple clinicians administering programmes while maintaining uniform standards and presentation.

It is hoped the findings and recommendations in this study will aid the HCPS as it continues to expand to meet the growing need for psychological health interventions in an ageing population. Despite the limitations in this study, group interventions can be a valued adjunct to therapeutic care for those living with CHCs.

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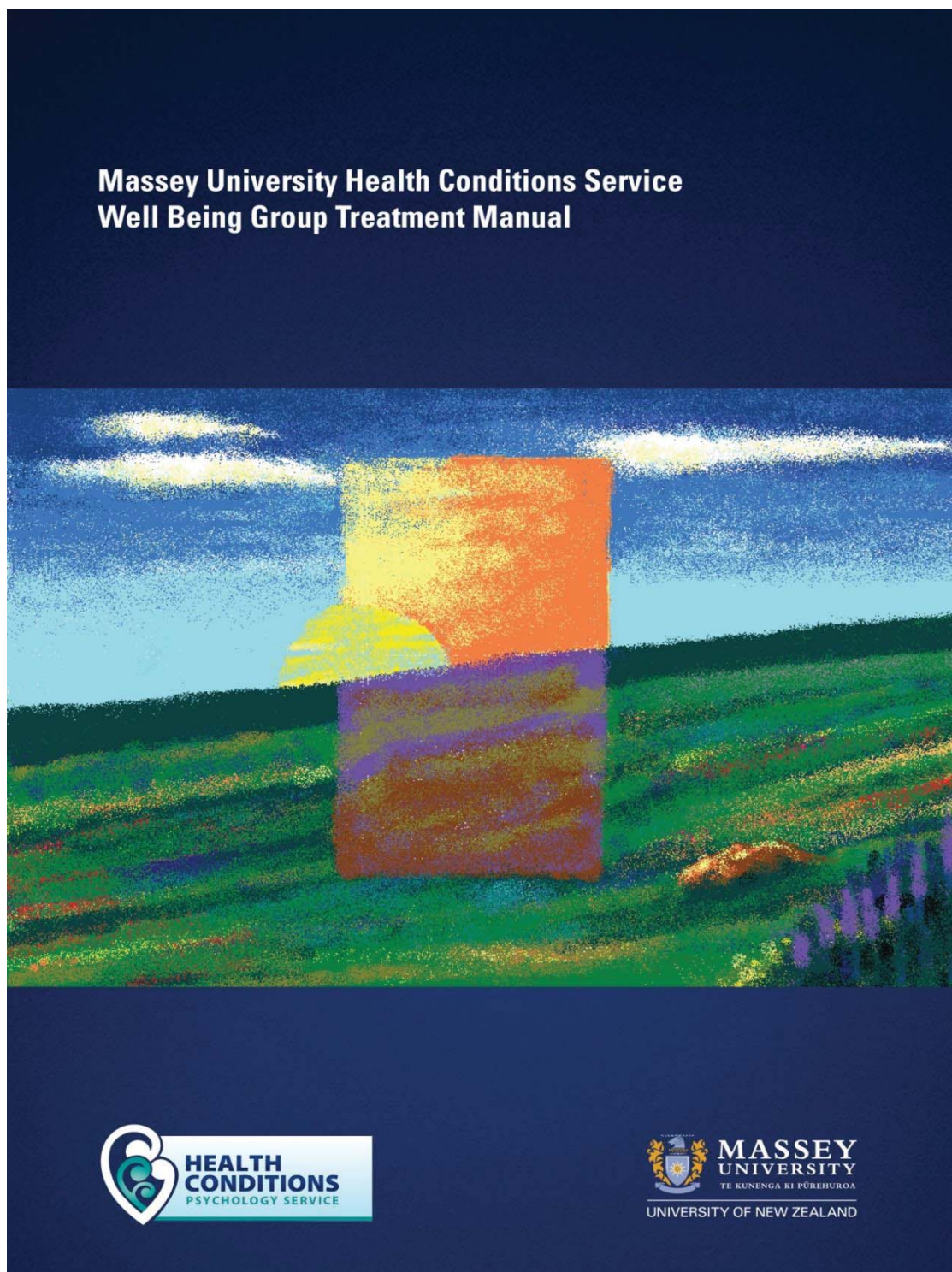
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APPENDICES

Appendix A MainWell-Being Treatment Manual



Massey University Health Conditions Service

Well-being Group Manual

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Introduction

1

On-going changes in the public health system challenge health services to adapt to meet the needs of the community such as providing timely cost effective treatment (Belar, 1997; Wagner, Austin, Davis, Hindmarsh, & Bonomi, 2001). One area of adaptation aimed at meeting these needs is the provision of group treatment for chronic health conditions within psychological services. Group treatment provides treatment that is cost-effective and easily transferable to diverse clinical settings and multiple locations. Furthermore, efficacious short-term group treatment offers clients benefits, such as the provision of quality care to individuals impacted by the effects of a chronic health condition (Bower, Kemeny, & Fawzy, 2002). In addition, group treatment can provide a setting that reduces the impact of social isolation (Bower et al., 2002). Hence, group treatment is potentially beneficial for the community and, as such, was selected as a treatment option to meet the needs of clients in a naturalistic clinical setting.

The following treatment programme, referred to as the 'Well-Being Group Treatment Manual' encompasses areas identified by literature on chronic or long-term health care treatment and research as relevant in dealing with chronic illness. Such literature suggests multiple key areas for targeted intervention, including psychological problems resulting from chronic health conditions. Although not an exhaustive list, psychological problems as a result of a chronic health condition include alleviating social isolation, increasing coping and problem solving skills, improving adherence to treatment protocols, and alleviating depression or psychological stress (Vamos, 2006). Thus, this treatment manual details the implementation of a brief six session group intervention programme aimed at addressing psychological problems.

Participants will be individual clients with a range of heterogeneous chronic health conditions such as, cardiovascular disease, chronic obstructive pulmonary disease (COPD), asthma, and diabetes. Therefore, a crucial aspect of the treatment programme is the need to be generic in nature. Although the range of chronic health conditions is diverse, the issues and problems that are resultant are often similar, and require an individual to develop flexibility and capacity in managing their health trends (Wagner et al., 2001). The programme requires active rather than passive participation. As such, participants need to be confident that they can expect to benefit from the programme and that their well-being will be enhanced (Schneider, Corey & Corey, 2006).

A central and underlying principle of the Well-Being Group Treatment programme, reflected in this manual, is that specific illness is not the primary focus. Rather, treatment focusses on improving quality of life (Devins, 2010) and alleviating psychological distress (Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002; Prifitis & Anthracopoulous, 2008). The manualised programme is conducted over six short-term sessions. The focus in developing this programme was to consider components and principles proven in existing short term treatments, across a number of chronic health conditions, for a diverse range of participants. Therefore, the sessions and strategies used in the programme follow an eclectic theoretical approach rather than a singular theoretical stance. The programme is intended for use by suitably trained and qualified psychologists only, in either clinic or health service provision settings. This is because the necessary knowledge required in applying the treatment components, strategies and

skills, needs to be combined with theoretical and clinical skills in order to deliver and assess the effectiveness of the treatment for each individual.

The delivery of the programme requires two co-leaders. This principle is in accordance with the current Massey University Psychology Clinic policy to ensure participant safety and optimum care. The policy requires that programmes of this nature employ two clinical co-leaders to present and conduct group sessions.

Given the complex nature of any group composition, a flexible approach is needed in order to adjust aspects of the programme to suit the group, or individual members of that group. It is expected that clinicians will remain flexible in the implementation of this programme and address both group and individual needs as these needs arise during a treatment session (Schneider, Corey, & Corey, 2006). For example, for some clients individual treatment may be more appropriate, especially if the referral question is not related to the key areas addressed by this programme. Therefore, as with all treatment programmes, relevance to individual clients and their specific target needs is paramount. While this is a group treatment, the focus should always be upon the individual.

Lastly, a screening process is employed prior to individuals participating in the programme to determine their suitability to the programme and group. Screening should assess practical difficulties that require consideration, such as an individual's physical needs or limitations. Also prior to joining the group, clients should receive sufficient information to enable informed consent. It is envisaged that the clinical group leader would be involved in this process because such involvement presents an opportunity to establish rapport and provide assurance about participating in the well-being group.

Clinician Tasks for All Group Sessions

- Welcome members of the group as they individually arrive.
- Ensure appropriate social learning opportunities arise for individuals within group interactions. This task requires clinician skills in group leadership and group processes.
- Identify and acknowledge the difficulty participants may have to overcome in order to attend the sessions. Recognise their courage, determination and achievement in attending in the face of adversity.
- Develop and establish a collaborative therapeutic relationship with each individual group member. A non-judgmental and empathetic manner will assist to maximise engagement and participation in the group
- Where necessary, remind the group of appropriate ground rules and the group contract.
- Structured group exercises occur at the beginning of a session. They are designed to alleviate apprehension and lessen dropout rates by aiding the development of group trust and cohesion. These exercises help to establish an environment whereby self-disclosure during the session is facilitated.
- It is important to describe the details of exercises clearly. Developing an effective therapeutic exercise begins with the group receiving clear direction and structure from the clinicians.
- Allow sufficient time for each exercise. Some exercises may require longer or shorter time periods than anticipated. However, of central importance is the ability of each exercise to function in a therapeutic manner. This may vary with the group needs.
- Keep the group focused by using prompts and asking timely therapeutic questions to enable further exploration of ideas within the exercises. Acknowledge, and where appropriate, positively reframe negative responses from participants. Use therapeutic skills, such as Socratic questioning, verbal prompts, open-ended questions, reflections, summaries and relevant examples, to encourage and develop responses from participants.
- Provide a small break between exercises to allow participants an opportunity to move around or rest. Some participants may need to move more frequently, and should be encouraged to attend to their needs and physical comfort.

4

- Introduce the concept and value of homework to the group in a non-threatening manner. Clearly explain homework is not evaluated. Rather, it is an opportunity to build skills learned in the sessions into everyday life.
- Allow sufficient time for participants to discuss difficulties. Put aside time as necessary for skills from the previous weeks that may need to be practiced or further explained.
- Ensure time is managed well during the sessions, and start and finish on time.
- Provide drinks and appropriate dietary snacks. Having a refreshments break allows participants the opportunity to form important informal social connections which are necessary for session interactions and discussions.
- In addition to psychometric assessment and health rating scales, the welcome, introduction, time for group reflection on the previous session and homework sections, provide an opportunity for the clinicians to assess change.

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Session One: Acknowledging Distress and Increasing an Awareness of Coping

Health research recognises the significance of psychosocial interventions which enhance adjustment to health conditions. Therapies in this manual focus on exploring positive or coexisting strength-based or coping skills, rather than focusing on a disease or illness deficits. Overall the aim of the first session is to increase a participant's ability to gain more control of their situation. The first session also aims to decrease participant distress by identifying, exploring, reinforcing and utilising coexisting coping strategies and strengths.

Session One: Goals

The purpose of session one is to aid participants to identify and strengthen their existing and innate personal skills and strengths. By the end of the session, participants should demonstrate the following knowledge, skills, and behaviour:

- Increased awareness of personal coping resources. Through identifying and focusing on coping abilities or resilience, participants can begin to actively approach current issues and difficulties in their daily lives.
- By being in the group and becoming familiar with other group members; participants will have an opportunity to expand their ideas, discover solutions and recognise opportunities for the future.
- On completion of the session, participants should feel that attending further sessions will be helpful, and of benefit to their particular situation and circumstances.
- Participants will become comfortable and familiar with the group setting and other group participants. The group setting will aid participants through providing an experience of empathic understanding which can aid in alleviating psychological stress.

Session One: Clinicians Tasks

- Welcome members of the group. Attending the first session can be stressful. Some may have feelings of wariness, vulnerability and be hesitant. Other participants may come late or require help on arrival. For this reason it is beneficial to have an assistant for the first half hour of the first session.
- Encourage reticent, shy or quiet participants that this is an opportunity for them. The programme offers them the choice and ability to determine their level of participation and change, which they can manage.
- Seek to form a collaborative therapeutic relationship with the participants. This provides encouragement and creates a climate of change for the participants.

- Introduce and explain the concept of the Biopsychosocial Model of Stress and the link between psychological, physical and social components.

Session One: Materials

- A white board, whiteboard markers and eraser.
- Work books.
- Name tags for participants. Collect at the end of each session.
- Blank cards for participants to use for Exercise 3.
- Extra paper and pens.
- Psychometric tools, Outcome Rating Scale (ORS), Short Form 12 (SF 12), Hospital Anxiety and Depression Scale (HADS). **NOTE: SF 12 is to be administered prior to starting the first session and administered at the end of the last session only.**
- Ensure ample supplies of writing material and pens are available.
- Beverages for the break, for example, tea and coffee supplies.

Session One: Outline

- Welcome and introduction.
- Structured group joining exercise: Introduce selves to the group.
- Group agreement and confidentiality contract.
- Overview of today and the remaining five sessions.
- Therapeutic Intervention: Identifying issues and difficulties which occur with a health condition.
- Introduce the Biopsychosocial Model of Stress.
- Homework and session wrap up. Administration of psychometric tools.

Session One: Exercises

Exercise 1: Welcome (5 minutes)

Hand out workbook and name tags as participants arrive. Ensure everyone has a copy before the session starts. Start the session with a welcome and personal introduction. Briefly expand on information about yourself and the services and facilities available to participants.

Sample Dialogue for Exercise 1:

Hello everyone. Welcome to the first session of the Health Well-Being group. I am ____, one of the clinicians for the group, along with _____. Either myself or _____ have had previous contact with you during your first appointment with the health conditions service. We are pleased that you are here with the Well-Being group.

I know that many of you have made a special effort to come here today. We would like you to make yourself comfortable and feel at ease, so please take care of your needs. If you want to move, stand up, or take a short stretch, feel free to do so. The toilets are located____. We plan to stop for a tea or coffee break at____ and will finish on time at____

During the next six sessions we have planned discussions and activities for you. The aim of these activities is to learn and practice them here, so you can try and implement them at home. We hope you will find them practical and useful, as well as providing you with strategies or other options you can use in everyday situations. You may have many things you already do which are effective and may want to share with the group what works for you. If you have any questions, suggestions or comments please just ask. As we get to know each other and share our experiences, it is likely that we shall cover issues which are personal in nature. We will discuss confidentiality in more detail soon and form a group agreement, but as a general rule in the meantime, we would like you to respect the confidentiality of others in the group by agreeing that what we discuss in the group remains in the group. I'd like to finish by saying welcome again to you all, and we look forward to working with you.

Exercise 2: Structured Group Exercise Group Introductions (15 minutes)

Direct the participants to page 4 of the individual workbook.

The purpose of an introduction is to provide participants a point of entry into the group. Clinicians should join in as it aids in building a supportive and meaningful environment. The participants also become accustomed to sharing information and details.

Sample Dialogue for Exercise 2:

In order to assist in getting to know everyone here, in a moment we are going to ask you to split up into pairs. Later, we will join up again and I will ask you to tell us all a little bit about the other person. To help you get to know each other, I would like you to find out the name of your partner and think of three things to share. First, what is your favourite food, next something unusual about yourself, for example, you may play the banjo. Lastly, what you would like to get from attending the well-being group. If you feel comfortable talking about your health please feel free to do so, but this is entirely over to you. If you would rather not, then that is fine. Ok, find yourself a partner, introduce yourselves and share those three things. Your favourite food, something unusual about yourself and what you would like to get from the group (5-10 minutes).

Ok let us come back together now. Would any pair like to go first, or shall I pick a pair (proceed to get feedback from all pairs). Would anyone like to add a comment about what it was like to do this exercise or something they learnt by doing this exercise?

Exercise 3: Group Agreement and Confidentiality Contract (10 minutes)

Direct participants to page 4 of the individual workbook. Get them to write in their workbooks.

A group guideline aids in establishing an effective, safe group environment built on trust and open communication. It outlines clear expectations of group behaviour and protocols that the group will be expected to adhere to, such as, attendance, mutual respect and confidentiality. The clinician can ask the whole group for suggestions, and write the contributions on the whiteboard as they are shared. Add essential points and make explicit aspects of confidentiality and other guidelines that may be overlooked by the group. The group rules can then be displayed during each session and a copy can be handed out at the next session as a further reinforcement of the group contract.

Whiteboard exercise:

Sample Dialogue for Exercise 3:

As a group I would like everyone to come up with a few ideas about guidelines we could have that will help us all to stay on track, and how we can protect each other's privacy and confidentiality. Let us contribute some ideas which you think are important, and will enable us to get the most out of this opportunity. What are some items that can be included?

Start and finish on time.	Return from breaks promptly
One person at a time speaking	Allow opportunities for everyone to speak
Have respect for each other	Respect different opinions to yours
Ask questions	Talk to facilitators if you have any concerns
Being supportive	Be non-judgemental of others
Participate as fully as you can	Confidentiality, privacy, and their limitations
Other new people may not join the group	
The right to pass if material is touching a highly sensitive topic	

Thank you for all of your input into developing our group contract. From now on we will use these guidelines during the sessions, and we may refer back to them from time to time as necessary.

Exercise 4: Overview of the Six Sessions and Today's Session (5 minutes)

Give a brief overview of the six sessions.

The purpose is to enable the participants an opportunity to confirm that their needs will be met. Also, they can add any other relevant items they may have. Thus, participant goals can be incorporated into the sessions.

Sample Dialogue for Exercise 4:

As I mentioned before, the Well-Being group will have six sessions. Particular illnesses or health conditions, such as diabetes or asthma, will not be the focus of these sessions. Instead we will be looking at issues which have arisen as a result of living with a long term health condition. On an individual level, there may be times where issues are raised which are distressing or upsetting. We have two clinicians here. Feel welcome to talk to a clinician individually should a need arise. Please feel free to do this. Know that you can approach one of us at any time. We will also check in with you all individually from time to time.

The aim of this group is to provide tools to further supplement skills you already have, or are currently using. The sessions will cover a wide range of topics including: identifying ways of managing stress, learning new ways to relax, gaining a sense of how we can use relaxation to control our bodies through biofeedback, enhancing social support and communication, and communicating with health professionals. Some of the material we will cover has been included in the workbook which you were given earlier. These are for you to bring along each week. As well as specific exercises that we will be running with you, it is important for you to realise that the group setting is an important place for us all to learn from each other. We can all benefit if everyone participates and shares their experiences, especially ones which may have worked for you.

Take a moment to introduce the remainder of today's session. Emphasise the aim is to enhance, explore and utilise coexisting coping skills. This approach helps develop an individual's satisfaction with their present life, despite having health limitations.

Sample Dialogue for Exercise 4 continued:

Today's session has initially focused on group agreements, introductions to each other and what is in store over the coming weeks. For the remainder of the session after the break, we will begin to explore and identify some of the difficulties of living with a health condition. We will also look at existing strengths and coping skills you may have, and different ways of building resilience in your life.

Pause for a break (10 minutes)**Exercise 5: Therapeutic Intervention - Identifying Issues and Difficulties that Occur with a Health Condition (35 minutes total)**

Direct participants to page 5 of the individual workbook.

The purpose of the intervention is to acknowledge, explore and validate the impact that living with a long term health condition can have. Despite such difficulties, each individual has inherent potential strengths, skills and ways they have coped effectively in the past. The Clinicians will need to help participants understand the brainstorming task.

Sample Dialogue for Exercise 5:

I would like to begin by acknowledging and recognising that having a health condition creates changes and challenges that can be very difficult for an individual and their family. Let us spend a few minutes and brainstorm some of the difficulties that arise. One example might be (prompt participants – for example, having less energy).

Part 1 (5 minutes)

Hand the participants the two blank cards required for this exercise.

Sample Dialogue Exercise 5, Part I:

We all realise that we have ways of coping and strengths that help us deal with issues. The next exercise we are going to do in two parts. During the first part everyone will work individually by themselves and write down their thoughts on a card. What you write down on your card is personal and we will not be sharing what is written on it. You will keep your card.

Each of us faces difficulties in our lives. Aside from a health condition, there are almost certainly other situations or experiences when you have faced tough times at different points in your life. Problems may differ for each individual, and what can be an obstacle or cause distress for one person may not necessarily affect another person. For now, I would like you to take a moment and think about some of these times. Without talking to anyone, try and recall other times in your life when you have faced difficult issues and stress. Jot down an example and as much as you can recall about a tough experience in your life on your card. For example it may have been a tough financial time or a close friend moved to another area. Does anyone have any questions or concerns about the task I am asking you to do now? When you have completed your writing, just wait quietly for everyone to finish. I would like to reiterate that this part of the exercise will not be shared.

During the reflection time, verbal prompts may be required for participants who finish quickly and may not have been effectively introspective. Prompts could include:

- o Try to write down as much detail as you can about your experience.
- o When did it occur in your life span?
- o What made it so difficult for you?
- o How it felt at the time?
- o How long were you in this situation for?

Part II (10 minutes)

For the next part of the exercise, emphasis is placed on what the participants did to help themselves. State to the group it is not the situation you want them to think about. Instead focus on strategies which they used. If a client is reticent then allow them the option to not take part, or to see a clinician individually.

Sample Dialogue for Exercise 5, Part II:

We all have strategies that we use when things are difficult. Now we are going to do the next part of the activity. I would like you to think about how you handled your difficult situation that you just wrote about. What did you do to help yourself? What was it that got you through or helped you in those difficult times? This time when we have finished writing, we will get into two groups and share some of the things you have written down on your second card. Specifically, I want you to focus on what you did to help yourself that worked.(for example you may have rung friends, become more involved in an activity, written a letter to your friend that had left, or created a budget).

Part III (10 minutes)

It is important for the clinicians to direct the talk in the small groups. Be prepared to give examples and to reframe examples positively, as necessary. Clinicians will need to explore with the participants strategies they use in difficult situations. Strategies may include seeking social support, such as friends or families, exercise, hobbies. Or it may be strategies such as tapping into personal qualities such as tenacity, optimism, humour, resourcefulness or resilience. Ask the participants:

Sample Dialogue for Exercise 5, Part III:

Ok let us split into two equal sized groups. We will give you further instructions on what to do once we are in our two groups.....How might these strengths, coping strategies or resources relate to your current situation? By identifying and amplifying the way we have coped in the past and applying it to our current situation, we can make a difference in the way we live our lives.

Part IV (10 minutes)

Some coping mechanisms may be effective short-term, but not over time. Therefore, it is essential to discuss why ways of coping may fail or be less effective long-term. Highlight the costs and risks involved in keeping the status quo. What are the benefits of no change? The objective is to encourage consideration about how learning new skills can reduce psychological distress. Importantly, link how current problems identified in the exercise by the participants will be addressed in the following sessions. Get participants to write in their workbooks. Allow time for a group discussion on specific examples from the participants own situations.

Individually**Sample Dialogue for Exercise 5, Part IV:**

Right now we are going to come up with some ideas. Let's brain-storm or come up with ways of implementing something that worked in the past alongside ideas about what we think might work for the future. Ok.... Let's think of something we have tried to do, or would like to try again (Check all clients have an example to work on). Think about whether past ideas or learning a new skill will improve your emotional or physical well-being? Will it bring benefits to other

people around you? It is important to remember that in many situations you cannot change what has already happened. But you can change what you do in the present moment and in the future.

Ask group members to share their thoughts to the whole group

Exercise 6: Therapeutic Intervention - The Biopsychosocial Model of Stress (25 minutes)

Direct the participants to page 6 of the individual workbook.

Psychological distress and problems identified by the participants are targeted by therapeutic components in this manual, which are integrated into a Biopsychosocial Model of Stress framework. Further, the Biopsychosocial Model of Stress will aid participant understanding of how complex factors in their lives can contribute to, and impact on their health and well-being.

Sample Dialogue for Exercise 6:

Just to recap; during today, we have identified personal ways of coping. Continue to keep in mind the way you have managed difficulties in the past. Recognise the benefits they may bring despite any limitations you may face in living with a long-term health condition.

Throughout the remainder of this session, and during the upcoming sessions, we are going to look at a range of additional strategies, which you can use to compliment what you already do well. The strategies we will teach you have all been well researched and have been shown to be beneficial for people dealing with a long-term health condition. Some of these strategies will be physical in nature, such as relaxation techniques. Another type of strategy will involve looking at the way we think about things such as our emotions or moods. Lastly, we will look at social relationships we have with other people, including friends and family and health professionals. While we anticipate these strategies will be useful to all of you, we also recognise that everyone is unique, and you may find some strategies more helpful or appealing than other strategies. This is to be expected, but we encourage you to practice and try out everything. Then decide which aspects you can incorporate into your life, which will be beneficial and helpful. We also encourage you to freely share your thoughts and experiences you have with these strategies with others in the group as we go.

Before we look at these strategies, we are now going to look at how the stress from living with a long term illness can affect us physically. We are going to begin by discussing what is known as the Biopsychosocial Model. The Biopsychosocial Model proposes that there are three different aspects which play a central role when it comes to how health or illness develops in a person's life. The model says that health is best viewed in terms of Biological, Psychological (including thoughts, emotions, and behaviours), and Social factors, rather than purely just biological or medical terms which has traditionally been the case.

Whiteboard exercise:

Draw a triangle (refer to Figure 1) to show three aspects of Biopsychosocial Model of Stress. Emphasise the interchangeability of the terms psychological/mind, physical/body, etc. Explain each of the areas and emphasise how there are many components and these all interrelate together in a complex and dynamic way.

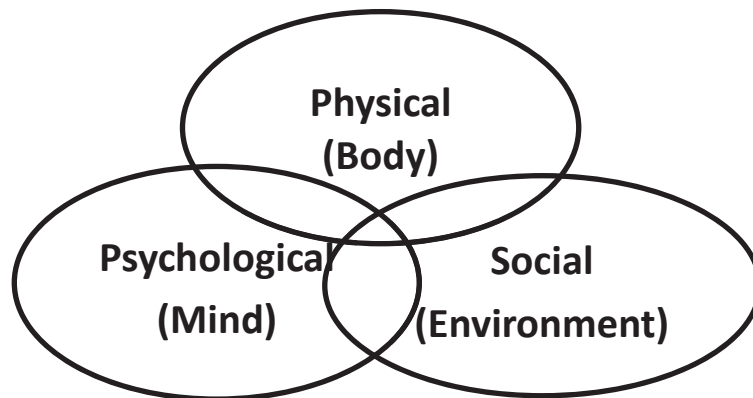


Figure 1. Biopsychosocial model related to stress.

Sample Dialogue for Exercise 6 (continued): Explanation of each of the areas:

Physiological/Body

Biologically, our bodies contain many complex and interrelated systems. Factors such as our genetic and physical make-up as well as naturally occurring diseases and infections can affect healthy biological functioning. For example a person may have a congenital defect present from birth such as Spina Bifida, or a heart defect. Another example could be an inherited genetic condition, such as Cystic Fibrosis lactose intolerance, or a breast cancer gene.

Psychological/Mind

The mind is influenced by psychological factors such as people's behaviours, their lifestyle and their personality. All of these factors have an influence on our health. For example, mental processes including the way people think about being sick, can affect their health. If a person ignores symptoms, and does not seek treatment or early intervention, this can affect their long term health. In contrast, someone else might think, I should get a check- up just in case. Emotions are yet another psychological factor which can affect an individual's health or management of health. An example of how emotions affect health might include feeling upset after an argument, which might lead to over eating, and affect glucose levels in a diabetic.

Social/Environmental Factors:

On a social level, people live in a multi-faceted environment. People are influenced by their culture and the communities they live in, their families, and other significant social relationships. Our environment shapes our values, habits, and beliefs on a continual basis. An example of this can be seen in smoking trends in New Zealand over the past 50 years. Smoking has ranged from widespread acceptance prior to the 1950s to the decline of use today. Society has influenced smoking behaviours by changing laws and increasing peoples understanding of the risks. Also, society is less tolerant of smokers themselves.

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Relate the smoking example to the way the Biopsychosocial Model of Stress interlinks and impacts on physical health (refer to Figure 2).

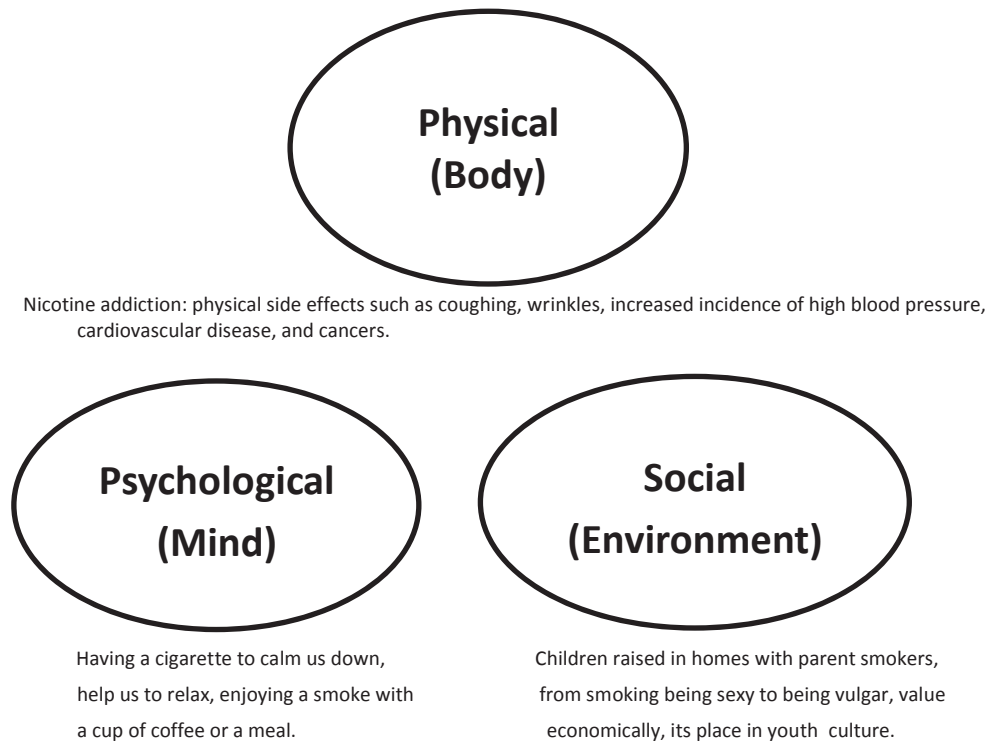


Figure 2. Biopsychosocial model related to nicotine addiction.

Sample Dialogue for Exercise 6 continued:

In summary, the Biopsychosocial Model recognises that there is a link between the mind, the body and the environment. It is holistic – that is, it considers that all aspects of a person's life can impact on their health and well-being. We have also seen it from the example of smoking how factors in one area, can influence factors in the other areas.

Homework (10 minutes)

Wind-down and summarise the session. Encourage participants by pointing out that they have accomplished a great deal of work today. The focus is on providing the participants with support to transfer work from in the session to carrying out interventions at home. Specific relevant compliments, or positive statements which target genuine attempts to set change in place, help to do this. Using the intervention for homework is a way of further encouraging participants to be creative, curious and open to new ideas.

Direct participants to page 8 of the individual workbook

Sample Dialogue for Exercise 7:

At the end of each session we would like you to continue working on things which have been covered today. One way we do this is by setting homework. This is not school homework and you will not be marked on it, but it is simply to practice and to include what you have learnt here into your daily living. Today, your homework is to keep a simple diary of a stressful or problematic situation you encounter this week. Notice your thoughts or emotions that you have at the time. We would like you to observe a few things about it based on categories we have highlighted from the Biopsychosocial Model. What was the situation? How did it feel physically and emotionally? What was occurring at the time? What did you do at that moment in time? What did you do later on in the day? Try and put down as much detail as you can. Think about how you reacted. Did the way you handled the situation work well? Can you brainstorm or think of different possibilities and different ways you could have handled your situation? Next week we will spend a few minutes as a group discussing what you discovered. We would like to hear about what happened. It would be helpful if you come prepared to share about this.

Participants Home Work Sheet

Describe and write down the difficult situation you faced using the Biopsychosocial Model as a guide.

What happened?

Where were you?

What were you doing?

Who were you with?

When did it happen? Day, time etc?

What were your emotions, thoughts or feelings?

What were your emotions? eg angry, sad, happy

What thoughts were going through your mind?

What memories or images were in your mind?

What was your physical response?

What did you notice happen physically?

Stomach knotted, sweat, shake, breathlessness, tired, sleepy, sick, dizzy, faint, dry mouth, muscle tensed etc

What did you do?

Ate, slept, argued, went for a walk, smoked, drank, laughed, called a friend, watched tv, went on the computer, spoke to person, changed the way I thought, focused on something else etc

Hand out psychometric tests to the group and have participants fill out and return them. (5 minutes)

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Session Two: Moving Towards Well-being by Using the Biopsychosocial Model of Stress

A body of research supports Engel's (1977) and Monat, Lazarus and Reevy's (2007) Biopsychosocial Model of Stress, and the existence of a profound link between the mind, the environment, and the body. The Biopsychosocial Model of Stress proposes that difficulties in any of these areas can have an immense effect on the body and impact on health. The strain of living with a long-term illness can further exacerbate and produce physiological reactions which can worsen a health condition. In particular, when psychological or physical stress is serious and prolonged, the body does not have time to adjust and recuperate. A wide range of health-related problems are thought to be aggravated or triggered by stress, for example, asthma or migraine headaches. For an individual with a long-term health condition, the stress caused by not coping can further negatively aggravate physical symptoms and overall well-being, thus creating a negative cycle. It is of course impossible to remove all stress and stressful reactions from daily living as this is neither realistic nor achievable. Rather, there is a need to find ways to reduce unhealthy stress and increase a relaxation response.

Session Two: Goals

The aim of this session is to introduce the Biopsychosocial Model of Stress concepts which link psycho-social or mental well-being to improved physical health. Finally, a new physical strategy, namely diaphragmatic breathing, is introduced to assist with managing the physical manifestation of stress.

- By observing others in similar situations living with a long term illness, interactions during the session will provide a setting in which individuals can make psychological gains. Participants will have an increased awareness of their own ability to have choices, despite the limitations which may exist when living with a health condition.
- The group setting will facilitate positive behaviour changes through promoting an increased and wider knowledge and awareness of the reciprocal relationship between the mind and body.
- The group will be able to identify the difference between stress, anxiety and depression, and situations or events that exacerbate stress.

Session Two: Clinicians Tasks

- Attend to individual participant responses. Negative narratives should be reframed and based on participant strengths, and be positive and restorative in nature.
- Briefly recap the concept of the Biopsychosocial Model of Stress and the link between psychological, physical and social components.

Session Two: Materials

- A white board and whiteboard markers.
- Extra work books.
- Name tags for participants. Collect at the end of each session.
- Blank Cards for participants to use for Exercise 3.
- Extra paper and pens.
- Psychometric tools. ORS, HADS.
- Ensure ample supplies of writing material are available.
- Beverages for the break, for example, tea and coffee supplies.
- Optional: long scarves for Diaphragmatic Breathing (at least one each, although some participants may require two scarves joined together depending on their chest circumference).

Session Two: Outline

- Welcome and introduction.
- Structured group joining exercise: The different aspects to our lives.
- Feedback on the previous week's events.
- Therapeutic Intervention: Chronic stress, and the relationship between chronic stress, anxiety and depression.
- Homework and session wrap up. Administration of psychometric tests.

Session Two: Exercises**Exercise 1: Welcome (5 minutes)**

Welcome participants to the session. Briefly remind participants about the facilities and the group confidentiality contract.

Sample Dialogue for Exercise 1:

Welcome to our second session. As with last week, remember to make yourself comfortable and to take care of your needs; move around if you need to. We developed group guidelines which we will briefly look at now as a reminder to us all..... The first session looked at the Biopsychosocial Model as a way to explain how complex a health condition can be and how different coping strategies may be necessary. Session 2 today will focus on some new strategies. Specifically, strategies that link to the psychological part of the Biopsychosocial ModelWe will also learn a relaxation technique which links to the biological or physical component of the Biopsychosocial Model.

Exercise 2: Structured Group Exercise the Different Aspects to Our Lives (10 minutes)

Direct the participants to page 9 of the individual workbook.

(Next Paragraph is Repeated Manual Instructions).

The purpose of the structured group exercise at the start of each session is to enable the participants a point of entry and time to connect into the group from the previous week. Clinicians should join in as it aids in building a supportive and meaningful environment. The participants also become accustomed to sharing information and details.

Sample Dialogue for Exercise 2:

It has been a week since we have seen each other. Let us take a minute to get reacquainted. The object of this exercise is to try and find something you have in common with someone else in the groupSplit up into small groups of three and let us find out a few things about each other. If there is something unusual or light hearted you want to share feel free to do so. Start with where and when you were born. How many people were in your family and what was your place or birth order in the family? Next move on to where you went to school. Once you have finished, find someone else to talk to. Let us see if there is anyone in the group with a similar background to each other. Would anyone like to comment on the point of this exercise?The point of this exercise is to highlight that there are many aspects to our lives despite having an obvious health condition. There are many ways we can connect with people, even people we don't know well, and find common ground in everyday situations.....

Exercise 3: Feedback on the Previous Week's Events (10 minutes)

Direct the participants to page 9 of the individual workbook.

Brainstorm

At this point it is important to lead and control the group in a manner which aids focus in a helpful and beneficial way. Importantly, participants who are able to adapt negative views and have more benevolent feelings toward their long-term illness and their current situation may have better outcomes than participants who retain rigid or firm thinking. Amplify, restate or reframe responses as necessary.

Amplifying Change

Encourage the participants with the knowledge that these opportunities occurred outside of therapy and originate from the participant themselves, rather than by chance or luck. Link individual participant actions to their experiences.

Restate or reframe

Restate or reframe negative comments by emphasising descriptions of the same situation in a positive manner. For example, if they comment they had a bad week because of their health condition, ask if there was a time during their week when they did not notice their condition. Emphasise positive change which may have occurred

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over the previous week. What have they attempted, discovered or seen has happened that is positive change?

Alternatively you can ask clients in small groups to discuss.

Sample Dialogue for Exercise 3:

Last week we looked at the Biopsychosocial Model and asked you to keep a diary of an event. What did you notice during the week?

How did you think some of your experiences could have impacted on your health?

How have you managed to continue this week despite difficulties?

What has worked for you over the week?

What is better?

Exercise 4: Therapeutic Intervention the Biopsychosocial Model of Stress (5 minutes)

The purpose of this psycho-education task is to recap briefly from the previous week. Emphasise how a range of complex factors in their lives can contribute to, and impact on their health and well-being. With increased awareness of the factors that may affect their current illness, participants will be better equipped to make positive changes that will improve the management of their health condition.

Sample Dialogue for Exercise 4:

Just to recap; during the last session and today, we identified some of our own personal strengths when we brainstormed past experiences and how we coped. We would like you to continue to keep in mind the strengths you recognised in your lives. Also your ability to call on and pursue these strengths despite limitations you may face with a long-term health condition. Importantly, implementing our strengths is one of a number of strategies we can use to help manage a long-term health condition.

We also looked at the Biopsychosocial Model. We saw how biological, psychological and social factors inter-relate and can have an effect on our health. We are going to continue from where we left of last week. Throughout the remainder of this session, and during the upcoming sessions, we are going to look at a range of additional strategies, which you can use to compliment what you may find helpful now. Some of these strategies will be physical in nature, such as relaxation techniques. Other strategies will involve learning new concepts, such as looking at the way we think about things. We will begin by looking at a psychological component of the Biopsychosocial Model and how the stress from living with a long term illness can affect us physically.

Exercise 5: Therapeutic Intervention Chronic Stress, and the Relationship between Chronic Stress, Anxiety and Depression (65 minutes total)

Part I (10 minutes)

Direct the participants to page 10 of the individual workbook.

The purpose of this psycho-education exercise is to give participants a basic conceptual understanding of the nature of chronic stress, and to highlight similarities and differences between stress, anxiety and depressive symptoms. Providing participants with an understanding of the different types of stressors, and how stress impacts on each person individually, increases their personal understanding of their own symptoms of stress. This understanding also assists in providing participants a rationale for the subsequent strategies they will learn throughout the remaining sessions, and enhancing recognition that a number of strategies can positively address the impact of on-going stress.

Sample Dialogue for Exercise 5, Part I:

We cannot escape the physical effects of some chronic health conditions (for example, we are often very aware of pain or of the loss of function in an area of our body), but other effects may pass unnoticed. One such effect is that of stress. Stress is the body's natural way of responding and preparing to meet a challenge or deal with a tough situation. The events that lead to the body reacting to stress are called stressors. They cover a wide range of situations from outright physical danger like swimming at the beach with sharks in the water, to less likely situations. For example, rushing to get to an appointment, going to the hospital to have tests done, having visitors come to stay for the weekend, or taking your drivers licence test. Stressors can be physical or psychological or social. You will notice that this is in keeping with the three areas of the Biopsychosocial Model we discussed earlier.

Whiteboard Exercise:

Ask Group members to share their thoughts with the whole group

What types of stressors can you think of that you have experience of or that you have seen others faced with? Get participants to write in their workbooks.

Place responses in the three categories as below:

Physical	Psychological	Social/Environmental
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Pause for a break (10 minutes)

Sample Dialogue for Exercise 5, Part I continued:

Even positive events are types of stressors such as winning lotto, or passing your driving test! When a person experiences a stressor, the human body responds by activating the sympathetic nervous system. Specific hormones from the endocrine system (called adrenalin and cortisol) are released directly into the blood stream, while at the same time; the body also releases extra glucose. The hormones help speed up our metabolism, heart rate, breathing, and blood pressure and give the body the extra energy it needs at that moment. This natural reaction is called the stress response. When working properly, the stress response helps us to react well under pressure and to respond to stressors. The stress response is critical during emergency situations like quickly grabbing a small child to stop them running into traffic, or when you need to give a speech. Later, once the danger or stressor has passed, and there is no longer a threat, then the level of arousal would gradually reduce and the body will relax. Overall, stress in small quantities can be extremely helpful.

However, sometimes chronic stress can occur at a lower level of arousal and over a longer period of time. The result is its effects can cause a significant impact on some people. We may have stressors in a number of areas personally such as with our health issues, difficulties in our families, our work environment, or in our social lives. This can cause our bodies to elicit a stress response. The sympathetic nervous system remains slightly activated and releases hormones and extra sugar over an extended period. While chronic stressors can differ in their duration or intensity; over time, the high level of hormones can leave a person feeling exhausted, depleted, and can lower immunity and increase a person's vulnerability to disease. Or, such as in the case of diabetes, it can affect sugar levels. Furthermore, different people may experience similar stressors or events but they do not necessarily respond in the same manner. How an individual views a situation, the coping strategies they may have, and their different emotional responses, can all affect stress levels. Overall though, too much stress isn't good for anyone.

Pause for a break (10 minutes)**Part II (10 minutes)****Whiteboard Exercise:**

Ask Group members to share their thoughts with the whole group

How does your body respond to stress? What does it look like? What are some of the physical and psychological symptoms? What happens, how long does it last?

Add to the participants brainstorming from the following list. Get the participants to write in their workbooks.

Chronic stress can lead to a wide range of symptoms, such as:-

- o Irritability
- o Sense of humour (laughing less these days? More serious?)
- o Worry (reliving or constantly going over things in your mind)

- o Excessiveness (eating, drinking too much, mood altering stimulants?)
- o Forgetfulness (can't remember little things?)
- o Aches and pains (headaches, gastrointestinal symptoms, muscle tension)
- o Nervousness (talking faster? Have to keep moving?)
- o Fatigue (feeling run down?)
- o Illness (allergies, colds, flu)
- o Time pressure (often feel there is not enough time? Too much to do?)

Sample Dialogue for Exercise 5, Part II:

Do you have three or more symptoms? You may be experiencing chronic stress symptoms.

Chronic stress can lead to a wide range of physical symptoms, such as:-

- o Increased blood pressure
- o Irregular heart beat
- o Increased cholesterol
- o Difficulty with breathing conditions such as asthma
- o Anxiety
- o Sleeplessness and insomnia
- o Joint pain
- o Irritating skin conditions
- o Changes in fertility, menstrual cycles and sex drive

Sample Dialogue for Exercise 5, Part II continued:

As you can see there are different aspects to stress and how it can affect our health. One way in particular stress can affect us is that it can mimic the same symptoms as anxiety and depression.

Part III (15 minutes)

Whiteboard Exercise:

Ask Group members to share their thoughts with the whole group

What does anxiety look like? What are some of the symptoms? What happens, how long does it last? Get the participants to write in their workbooks.

Common Anxiety symptoms

Ask group members to share their thoughts with the whole group

1. Dissociative symptoms such as feeling numb, detached, a reduction in awareness surroundings, or disorientation.
2. Significant anxiety, nausea, vomiting.
3. Dry mouth.
4. Excessive sweating.
5. Irritability.

6. Poor concentration, such as difficulty thinking, forming thoughts or following conversations.
7. Difficulty sleeping.
8. Restlessness.
9. General feelings of anxiety such as excessive worry, fear of losing control, sudden attacks of intense fear or anxiety.
10. Panic Attacks, heart beat problems, heart palpitations, tightness in the chest, fear of having a heart attack, fear of dying from a heart attack.
11. Physical breathing symptoms such as not breathing properly, rapid breathing or shortness of breath.
12. Blurred vision and dizziness.

Part IV (15 minutes)

Whiteboard Exercise:

Ask Group members to share their thoughts with the whole group

What does depression look like? What are some of the symptoms? What happens, how long does it last? Get the participants to write in their workbooks.

Common Depression symptoms

Ask group members to share their thoughts to the whole group

1. Loss of interest in activities.
2. Changed sleep patterns.
3. Changed eating habits and unintended weight change.
4. Decreased grooming activities and lack of interest in personal appearance.
5. General unhappiness lasting a prolonged period of several weeks.
6. Loss of interest in sex.
7. Suicidal thoughts.
8. Frequent accidents.
9. Low self-image.
10. Irritability.
11. Loss of energy.
12. Difficulty making decisions.

Part V (15 minutes)

Whiteboard Exercise:

Ask Group members to share their thoughts with the whole group

How should the symptoms of stress, anxiety and depression be managed? Get the participants to write in their workbooks.

Ask group members to share their thoughts to the whole group

Suggestions may include:

Talk to health professionals.

Psychological therapy such as CBT or other talking therapies.

Increase pleasant activities.

Increase exercise.

Attend to well-being health such as good sleeping and eating habits.

Consider requesting medication from your GP.

Spend time with supportive family and friends.

Talk to phone counsellors such as Samaritans.

Avoid alcohol or other recreational drugs.

Use internet resources such as <http://www.depression.org.nz>

What should we do if the symptoms are serious?

Refer or seek professional medical help at any stage, but especially if you are experiencing:

Severe depression

Persistent depression symptoms

Profound hopelessness

Significant functional impairment like being unable to do most daily activities

Suicidal thinking

Emphasise that the sessions will focus directly on strategies to help manage or reduce distress symptoms that affect all areas of the Biopsychosocial Model of Stress.

Sample Dialogue for Exercise 5, Part IV:

As much as stress, anxiety and depressive symptoms can affect us and our long term health condition, there are also a wide range of techniques we can use to train our mind and body to reduce stress, anxiety and depression. Over the coming weeks we are going to look at what we can do to reduce the effects of stress, anxiety and depression in all of the areas covered by the Biopsychosocial model.

Homework (10 minutes)

(Next Paragraph is Repeated Manual Instructions).

Direct the participants to page 12 of the individual workbook.

Wind-down and summarise the session. Encourage participants by pointing out that they have accomplished a great deal of work today. The focus is on providing the participants with support to transfer work from in the session to carrying out interventions at home. Specific relevant compliments, or positive statements which target genuine attempts to set change in place, help to do this. Using the intervention for

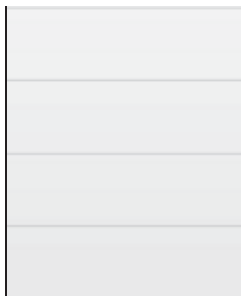
homework is a way of further encouraging participants to be creative, curious and open to new ideas.

*Draw an example of the left-hand side graph on the whiteboard. **NOTE** only blank graphs appear in the participants work book.*

Sample Dialogue for Exercise 6:

At the end of each session we would like you to continue working on things which have been covered today. One way we do this is by setting homework. This is not school homework and you will not be marked on it, but it is simply to practice and to include what you have learnt here into your daily living.

For your homework today think about your stress levels over the coming week and record where your levels are each day. The bottom line of the graph indicates having some levels of stress is normal. The middle line indicates the level of stress we can tolerate despite it being elevated especially, if there are periods of decline. However, the top line indicates on-going stress at a high level without significant decline. Some days are not stressful, while other days we recognise our stress levels are high. Keep a daily track of where your levels are. Where is your baseline?



Next week we will spend a few minutes as a group discussing what happens. We would like to hear about what you did and it would be helpful if you come prepared to share about this then.

Hand out psychometric tests to the group and have participants fill out and return them (5 minutes).

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Session Three: Strategies for Managing Distress

People with long-term health conditions often have other non-physical problems brought on by their health condition, such as worry, chronic stress or depression. In particular, these problems occur for people who experience significant levels of disability or pain. Importantly, self-care can be directly compromised and, as a result, other areas of functioning decline, such as treatment adherence. In addition, a chronic health condition is rarely static in nature. Fluctuations of highs and lows with a condition can and do occur, adding to an individual's distress. As a consequence, individuals encounter an additional and necessary burden to develop skills and strategies that will assist them to cope effectively, and reduce the effects of worry, stress or depression.

Session Three: Goals

The focus of session three is to increase the ability to attend to relaxation activities which are normally not noticed or are perhaps done without thinking.

- Each participant will experience the physical benefits of a relaxation technique in the session.
- By the end of the session, each participant is able to complete a relaxation exercise.
- The experience of the concept and physical benefits of relaxation encourages participants to consider spending time in relaxation activities.
- Participants will learn how to activate a relaxation response. Using relaxation methods will reinforce efforts to become less sensitive to stressful stimuli and to cope with stress and anxiety by using strategies learnt in today's session
- Participants will use a relaxation CD produced by the Massey Psychology Clinic, as a tool to aid learning a relaxation method which suits their particular style.
- By being in a group, individuals will develop balanced, positive and healthy thinking towards the benefits of relaxation. Relaxation will also aid in dealing with a health condition and its symptoms. Although it will not make the issue of living with a long term illness go away, it will make it more tolerable.

Session Three: Clinicians Tasks

- Emphasise that the key to success with implementing relaxation techniques is perseverance. The participant will need to acquire a set of skills and practice them until mastery is achieved. Success with the skills may not be achieved immediately.

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- Emphasise the importance of applying the knowledge learnt today (and from previous sessions) in daily life. Help participants to accomplish realistic and specific actions, and encourage them to practice applying the skills they have learnt.
- Ensure participants have a clear understanding that relaxation reduces arousal and addresses chronic stress and depression. Explain how relaxation reduces arousal and addresses chronic stress.
- Provide highly descriptive accounts of the techniques so that the participants can gain a thorough understanding. It is especially important to explain efficacy, and practical issues, that can be involved with using the techniques. The group needs to be aware that the techniques used today are highly experiential, and should be positive and restorative in nature.
- Encourage participants to actively participate and use all of their senses such as olfactory, tactile, auditory, visual, and taste. Encourage participants to enhance and feel the effects of natural phenomena such as the heat from the sun.
- Adapt relaxation scenarios and techniques to fit with the participants. For example, visual relaxation scenes which include a beach would be inappropriate for a participant with a fear of drowning. Other tranquil scenes can include mountain vistas, lavender fields, sunsets, waterfalls and mountain lakes.
- Emphasise the need for repetition and practice for all of the relaxation exercises. Suggested therapeutic rates for relaxation techniques are at least 15 minutes, three times a day.

Session Three: Materials

- A white board and whiteboard markers.
- Extra work books.
- Name tags for participants. Collect at the end of each session.
- Extra paper and pens.
- Relaxation CD for participants to take home.
- Psychometric tools. ORS, HADS.
- Ensure ample supplies of writing material are available.
- Beverages for the break, for example, tea and coffee supplies.
- Essential oils and candles (these can be used in the room to create a relaxing ambience and atmosphere).

Session Three: Outline

- Welcome and introduction.
- Structured group joining exercise. Introducing selves to the group.

- Feedback on the previous week's events.
- Therapeutic intervention: Diaphragmatic Breathing.
- Therapeutic intervention: Sunlight Meditation relaxation technique.
- Homework and session wrap up. Administration of psychometric tools.

Session Three: Exercises

Exercise 1: Welcome (5 minutes)

Clinician welcomes participants to the session.

Welcome all the participants and continue to attend to establishing and maintaining a positive therapeutic alliance.

Sample Dialogue for Exercise 1:

Over the last two weeks we have looked at implementing our existing strengths, the Biopsychosocial model, and how it impacts on stress, anxiety, and depression. Today we will learn strategies to help address some of the physical effects of chronic stress that comes with having a long term illness. In today's session, we will introduce two different types of relaxation techniques. But first we will begin with a group exercise to reconnect with each other. Then we will review homework from last week.

Exercise 2: Structured Group Exercise Identifying and Labelling Affect (10 minutes)

(Next Paragraph is Repeated Manual Instructions).

Direct the participants to page 13 of the individual workbook.

The purpose of the structured group exercise at the start of each session is to enable the participants a point of entry and time to connect into the group from the previous week. Clinicians should join in as it aids in building a supportive and meaningful environment. The participants also become accustomed to sharing information and details. Today's exercise is to help establish and facilitate an environment whereby the identification of emotions and the use of vivid imagination will be more readily accessible during the session.

Sample Dialogue for Exercise 2:

Today I want us to become more aware of how we can intentionally use our imagination for our benefit and to alleviate or reduce some stress. To help us do this, we are going to start by thinking about our emotions in a new way. Everyone close your eyes...(pause). Think about today and what has happened prior to coming and arriving here...(pause). How do you feel? ...(pause) How do you feel right now at this particular moment in time?...(pause). What emotion are you feeling? Think about your current emotion as if it is a colour...(pause) What colour is it? Is the colour bright or dull?...(pause). Think, about how your emotion feels. Is your emotion big or small?...(pause). What does it look

like, is your emotion round or square? Does it have rough jagged edges, is it pointy or sharp? Maybe it has rounded edges? Perhaps it feels smooth or shiny or velvety...(pause). Ok, now open your eyes... Find a partner next to you...In pairs, use words as imaginative as possible which describe the shape and colour of how you feel. Then tell each other why you have chosen those descriptions to identify your feelings...

Exercise 3: Feedback on the Previous Week's Events (10 minutes)

Direct the participants to page 13 of the individual workbook.

(Next Paragraph is Repeated Manual Instructions).

Brainstorm

At this point it is important to lead and control the group in a manner which aids focus in a helpful and beneficial way. Importantly, participants who are able to adapt negative views and have more benevolent feelings toward their long- term illness and current situation may have better outcomes than participants who retain rigid or firm thinking. Amplify, restate or reframe responses as necessary.

Amplifying Change

Encourage the participants with the knowledge that these opportunities occurred outside of therapy and originate from the participant themselves, rather than by chance or luck. Link individual participant actions to their experiences.

Restate or reframe

Restate or reframe negative comments emphasising descriptions of the same situation in a positive manner. For example if they comment they had a bad week because of their health condition, ask if there was a time during their week when they did not notice their condition. Emphasise positive change which may have occurred over the previous week. What have they attempted, discovered or seen has happened that is positive change?

Sample Dialogue for Exercise 3:

What positive change has occurred in your lives over the previous week? What have you attempted, discovered, or seen happen that is a positive change? How has thinking about your levels of stress depression and anxiety helped? What impact did using a graph to record your stress levels have? What have you noticed about the effect of stress and its impact physically on you? How have you managed to continue this week despite difficulties? What has worked for you over the week? What is better?

Exercise 4: Therapeutic intervention Diaphragmatic Breathing (25 minutes)

Direct participants to page 14 of the individual workbook.

Important: it is essential that participants are screened for possible contra-indications, especially participants with restrictive breathing conditions or physical conditions who may suffer harm if they attempt to carry out this exercise.

The purpose of this exercise is to introduce a physical relaxation strategy to participants. The intention of diaphragmatic breathing is to provide a period of a more relaxed state, which will last for a brief period of time after the session has ended. Optional: The clinician can demonstrate this technique by holding a scarf wrapped around their chest with one hand, while the other hand is positioned on the stomach. The idea is to breathe and inflate the lower abdominal area (felt by the hand on the stomach), before the chest area rises. Link the technique to the Biopsychosocial Model of Stress and emphasise that the following exercise is related to the biological or physical component.

Sample Dialogue for Exercise 4:

Before beginning the relaxation exercises take your pulse rate and note it down (7 minutes)

While it is not reasonable sometimes to eliminate all stress, we can learn to control its intensity and duration. Relaxation can help when we experience emotional discomfort or physical pain. Relaxation uses techniques or images we have created to distract us, restore energy, and gain a measure of control at that time. It helps reduce the impact of the physical effects of a health condition by increasing a conscious awareness of being able to produce soothing effects on your body.

There are some practical tips which can help us get the most benefit we can from using relaxation techniques. Find somewhere quiet where you will not be interrupted for at least 15 to 20 minutes. Make sure you are wearing loose fitting clothing, and sitting or lying comfortably. You will need to implement the techniques at least five times a week, but daily is more beneficial. Relaxation may feel boring, but be patient. It may take a couple of weeks of frequent practice before results are noticeable.

A technique we can use to reduce the effects of stress is through using a physical strategy such as breathing techniques. Abdominal or diaphragmatic breathing is a technique which uses controlled breathing through abdominal or lower stomach expansion as a means of relaxation. It is easily learnt in a short period of time and once you are proficient, diaphragmatic breathing can be done very intentionally almost anywhere and at any time. Diaphragmatic breathing does require concentration. If you find that your mind begins to wander, it is important to refocus back onto your breathing. The aim is to experience slow and relaxing breathing.

Find somewhere quiet where you will not be interrupted for at least 15 to 20 minutes. Make sure you are comfortable, either sitting down or preferably lying prone on the floor, with your eyes

closed. Any tight clothing should be loosened. Place your hands or a book on your stomach and feel it rise and fall underneath your hands as you breathe each breath.

Inhale for 3 seconds. Become more deeply aware of the flow of air as it enters into and leaves your body. Feel the air as it moves through the nose or mouth, down into the lower part of the lungs. Consciously try and fill air into all of the regions in your lungs. Pause for a brief moment but do not hold your breath, then slowly breathe out for 3 seconds. Notice how the stomach rises and falls when the air is exhaled. Feel the air leave the lungs and travel up through the throat and out the mouth. Pause for a brief moment without holding your breath and breathe in again. Try and control the pace and each phase of the breathing cycle. Attempt to expand your abdomen rather than your chest, although it will naturally rise as well. Observe how relaxed your body becomes as you breathe out, your stomach, shoulders and chest.

Ask group members to share their thoughts with the whole group.

Pause for a break (10 minutes)

Exercise 5: Therapeutic intervention: Sunlight Meditation (Bourne, 2005) (25 minutes in total)

Direct the participants to page 16 of the individual workbook.

The purpose of the following exercises is to induce a relaxation response. By giving participants practical examples of various relaxation techniques, they can find a method of relaxation that suits them. The health benefits that can be experienced through the use of relaxation are many and varied.

Relaxation can lead to improved sleep, reduced stress hormone levels, reduced pain, lower blood pressure and can induce a variable heart rate. Yet, knowing how to relax can be difficult.

Clinician to the whole group

Sample Dialogue for Exercise 5: (15 minutes)

The next technique we will learn today is a type of a progressive muscle relaxation technique. During this type of exercise, most of the major muscle groups are systematically and completely relaxed. With practice, it is possible to learn to distinguish when your muscles are becoming tense and to use muscular relaxation to bring relief. Picture yourself in a safe, beautiful place outdoors... Now imagine that you feel a warm, gentle breeze blowing over your body. Overhead you can see a beautiful blue sky and some white clouds. Shining directly overhead is the sun...

Now imagine that you can feel the warmth and light from the sun directly above you. You can feel it shining down—in and through your entire body. You feel it beginning to relax and soothe every part of your body. In a moment, you might concentrate on this sunlight and move it over to your right arm. Focus it there... Just experience the warmth and light from the sun penetrating the fingertips of your right hand. You can feel it soothing and relaxing your right hand. And in a moment it begins to move from your right hand to your forearm... and then to your upper arm... and then to your shoulder... Just feel the sunlight warming and soothing your entire right arm. You can feel it filling and soothing every muscle, tendon, and nerve in your right arm. And you feel your right arm—from the tips of your fingers to your

shoulders—becoming completely relaxed. And you find yourself just letting go more and more ... becoming more and more at peace.

Now move the light from the sun to your left arm. Imagine it entering and soothing your left hand. And in a moment you can begin to feel it moving from your left hand up your left arm... soothing your forearm... and then your upper arm... moving all the way up to your shoulder. You're relaxing all the muscles, nerves, and tendons in your left arm ... feeling the light penetrating and soothing your entire left arm. Just continue to let yourself drift deeper and deeper into quietness and peace...feeling very safe, secure, and relaxed.

And, gently now, take the light from the sun and move it over to your right leg. Allow it to move from the tips of your toes all the way up your right leg to the big hip joint. Feel the warmth as the sunlight moves up through your right leg, from your right foot to your right calf... and then to your right knee... and then to your right thigh... and finally to your right hip bone. Just feel the sunlight penetrating and soothing every muscle, tendon, and nerve in your right leg and hip. Your entire right leg is feeling completely relaxed.

And in a moment, feel the sunlight move to your left leg. Again, allow it to move from your left foot up through your entire left leg to your hip bone. Feel it soothing and relaxing your left ankle... then your calf... and then your knee... and then soothing all the muscles in your thigh and finally moving up into your hip. You can feel the sunlight penetrating every muscle, tendon, and nerve in your entire left leg. And in a moment you find your left leg feeling completely relaxed.

And now move the light from the sun into your stomach area. Just feel it warming and soothing every organ in the lower part of your body. Just feel the pressures and tensions of the day draining away from you... as your stomach and lower abdomen relax completely. Feel your stomach and lower abdomen becoming very relaxed.

Now take the light from the sun and move it into your chest area. Let it soothe and comfort that area. Just feel it streaming into your chest. You're feeling relaxation...peace...and comfort throughout your entire chest feeling your chest becoming very relaxed and your breathing becoming easy.

Now, in a moment, you might bring the light from the sun down through the top of your head. Imagine it soothing and comforting the top of your head...and then the area around your eyes...and then your jaws. And in a moment, feel the warm, soothing sensations of the sunlight moving down into your neck, relaxing and releasing every tight muscle in your neck. And in a while you can feel your neck completely relaxing. Your head and neck are becoming completely relaxed.

And now let the sunlight move down your spine, down through your spine all the way to your tailbone...feel it moving down through your spine all the way to your tailbone. And then imagine the light moving out from your spine into every nerve of your body. Feel the sunlight moving into every nerve of your body, healing and relaxing all of those nerves. And as all of your nerves relax, you can enter into a very deep state of peace. Just allow yourself to drift deeper and deeper into quietness and peace...becoming more and more relaxed. In a moment you can feel the sunlight relaxing and soothing every single cell in your body. Every single cell in your body is becoming very relaxed. And you feel yourself becoming very deeply relaxed...very much at peace.

Direct the participants to page 18 of the individual workbook.

After the relaxation exercises retake your pulse rate. (7 minutes)

Ask group members to share their thoughts with the whole group (5 minutes)

Homework (10 minutes)

Direct the participants to page 18 of the individual workbook.

(Next Paragraph is Repeated Manual Instructions).

Wind-down and summarise the session. Encourage participants by pointing out that they have accomplished a great deal of work today. The focus is on providing the participants with support to transfer work from in the session to carrying out interventions at home. Specific relevant compliments, or positive statements which target genuine attempts to set change in place, help to do this. Using the intervention for homework is a way of further encouraging participants to be creative, curious and open to new ideas.

Sample Dialogue for Exercise 6:

Your homework today is to take home and listen to the relaxation CD and read the printed versions in your handbook?

Which type of relaxation method suits you? When will you practice doing the relaxation technique that you have chosen?

How often can you do it? Next week we will spend a few minutes as a group discussing what happens. We would like to hear about what you did and it would be helpful if you come prepared to share about this then.

Hand out psychometric tools to the group and have participants fill out and return them (5 minutes).

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Session Four: Biofeedback

For people with long-term health conditions, achieving total physical wellness is frequently not an aim. Some participants are faced with the likelihood of ongoing and permanent health decline. Even so, health conditions generally do not follow a linear pattern of decline; rather there are often ebbs and flows of illness effects over time. Being able to maximise ones potential and gain a sense of self-control, despite a health condition, is a dynamic and continuing process. Among other things, the process involves maximising physical, intellectual, emotional, and social attributes as part of a balanced lifestyle.

Today's session includes a practical demonstration of increasing some physical control by using a biofeedback machine. Using a biofeedback machine can powerfully illustrate an individual's ability to have some control over physical aspects of their health.

Session Four: Goals

- Use biofeedback to help demonstrate the relationship between mind and body. Biofeedback will also practically demonstrate physiological changes that occur when people intentionally attempt to relax.
- Use biofeedback to increase and reinforce the use of relaxation behaviours and sensations, including those learnt in previous sessions.
- Use group participation as an opportunity for participants to observe how others react physically in a similar situation, and enhance belief that one can have control over aspects of their physiology.

Session Four: Clinicians Tasks

- Clinicians should be familiar with biofeedback equipment.
- Emphasize the application of relaxation techniques and integrating skills learnt in previous sessions. Biofeedback is an important reinforcing tool for learning relaxation techniques.
- Ensure participants have a clear understanding of the link between the relaxation response and a change in physiological functioning.
- Use biofeedback as a teaching aid for participants to become more self-aware of their ability to have some control over their body.

Session Four: Materials

- A white board and whiteboard markers.
- Extra work books.
- Computer laptops.
- Name tags for participants. Collect at the end of each session.
- Biofeedback programmes or equipment such as Emwave.
- Extra paper and pens.
- Psychometric tools. ORS, HADS.
- Ensure ample supplies of writing material are available.
- Beverages for the break, for example, tea and coffee supplies.
- Power extension cords.
- Optional: Essential oils and candles (these can be used in the room to create a relaxing ambience and atmosphere).

Session Four: Outline

- Welcome and introduction.
- Structured group joining exercise. Relearning a skill.
- Feedback on the previous week's events.
- Therapeutic intervention: Biofeedback.
- Homework and session wrap up. Administration of psychometric tools.

Session Four: Exercises**Exercise 1: Welcome (5 minutes)**

Clinician welcomes participants to the session.

Today's Session

Take a moment to introduce today's session.

Sample Dialogue for Exercise 1:

Welcome everyone. Today's session will use a strategy called biofeedback. Biofeedback helps to emphasize and explore how we can gain some control over our bodies despite having physical limitations or struggling with a health condition. We will show you how we can help trigger a relaxation response by using biofeedback. Basically, the biofeedback we will use today is a computer programme that monitors and helps you increase variability in your heart rate. But first we will begin with a group exercise to reconnect with each other and then next we will review homework from last week.

Exercise 2: Structured Group Exercise Re-Learning a Skill (10 minutes)

Direct the participants to page 19 of the individual workbook. (*Next Paragraph is Repeated Manual Instructions*).

The purpose of a structured group exercise at the start of each session is to enable the participants a point of entry and time to connect into the group from the previous week. Clinicians should join in as it aids in building a supportive and meaningful environment. The participants also become accustomed to sharing information and details.

White Board Exercise

Sample Dialogue for Exercise 2:

The following is a task which uses an everyday skill but helps to demonstrate how difficult it is to change or do something in a different way. If you are right handed, try writing your name and address on a piece of paper with your left hand (or visa-versa). Next, try writing your name and address neatly with your eyes closed. Turn the paper upside-down and try writing it upside down. It is much easier to write in a way we are familiar with than to persist and learn a new way unless we have to.

How does this relate to learning the new skills of relaxation that you learnt in the last two weeks?

Give the group an opportunity to discuss what occurred. The purpose of this exercise is to show that change, or doing something new, can create different types of pressures that can vary from individual to individual. Some people may react to change differently, but it can be especially hard overcoming uncertainty, learning something new, or re-learning a skill in a different way.

Exercise 3: Feedback on the Previous Week's Events (10 minutes)

Direct the participants to page 19 of the individual workbook.

(*Next Paragraph is Repeated Manual Instructions*).

Brainstorm

At this point it is important to lead and control the group in a manner which aids focus in a helpful and beneficial way. Importantly, participants who are able to adapt negative views and have more benevolent feelings toward their long- term illness and their current situation may have better outcomes than participants who retain rigid or firm thinking. Amplify, restate or reframe responses as necessary. Encourage participants to share by asking how the previous week's techniques have impacted on them.

Amplifying Change

Encourage the participants with the knowledge that these opportunities occurred outside of therapy and originate from the participant themselves, rather than by chance or luck. Link participant actions to their experiences.

Restate or reframe

Restate or reframe negative comments by emphasising descriptions of the same situation in a positive manner. For example if they comment they had a bad week because of their health condition, ask if there was a time during their week when they did not notice their condition. Emphasise positive change which may have occurred over the previous week. What have they attempted, discovered or seen has happened that is positive change?

Sample Dialogue for Exercise 3:

Last week we looked at two different relaxation techniques, namely diaphragmatic breathing and a progressive muscle relaxation technique called sunshine meditation. We also handed out a CD which you could listen to with the exercises on it. How have you managed to implement the relaxation techniques in your daily life? What positive change has occurred in your lives over the previous week? What have you attempted, discovered, or seen happen that is a positive change?

How have you managed to continue this week despite difficulties?

What has worked for you over the week?

What is better?

Exercise 4: Therapeutic Intervention Biofeedback (70 minutes)

Direct the participants to page 19 of the individual workbook.

The purpose of biofeedback is to aid participants in developing self-regulation skills which induce relaxation and can lead to an improvement in health. Use one of the clinicians as the first volunteer to demonstrate biofeedback, while the other clinician explains what is occurring.

Sample Dialogue for Exercise 4:

Like stress, some emotions such as being frightened, angry, or anxious can cause physical changes to occur in the body. Some of the physical symptoms people often notice are things such as heart palpitations, butterflies in the stomach, sweaty hands, skin flushes, a dry mouth or incoherent speech. Another part of the body that reacts to stress and is easily identifiable is the eye pupils. If someone is startled, the eyes change rapidly in size.

Biofeedback is more than an information tool for what is occurring in our bodies. It also is a valuable tool which teaches us to be able to recognise and develop an increased level of self-awareness. It helps us exert a level of self-control over what our body is doing. Biofeedback is a useful tool as it shows us what happens when a body starts to relax. It is designed to help reinforce the relaxation skills which we learnt last week. It can also show you how much control you can have over the impact of stress in your life.

This session is dedicated to providing participants with the opportunity to personally witness or experience biofeedback. Take time to ensure participants understand the use of biofeedback and what it measures, and that they have time to ask questions about

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how relaxation can affect their symptoms. If possible, ensure all participants are able to have a turn using biofeedback.

Pause for a break after the session has been going for one hour (10 minutes).

Continue with biofeedback.

Homework (10 minutes)

Direct the participants to page 20 of the individual workbook.

(Next Paragraph is Repeated Manual Instructions).

Wind-down and summarise the session. Encourage participants by pointing out that they have accomplished a great deal of work today. The focus is on providing the participants with support to transfer work from in the session to carrying out interventions at home. Specific relevant compliments, or positive statements which target genuine attempts to set change in place, help to do this. Using the intervention for homework is a way of further encouraging participants to be creative, curious and open to new ideas.

Sample Dialogue for Exercise 5:

Your homework today is to continue with the type of relaxation method that suits you. Next week we will spend a few minutes as a group discussing what happens. We would like to hear about what you did and it would be helpful if you come prepared to share about this then.

Hand out psychometric tests to the group and have participants fill out and return them (5 minutes).

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Session Five: Communication with Health Professionals and Identifying Barriers to Implementing Change

Nowadays, health professionals encourage people to identify their own self-care goals and to work towards these. However, health-care providers often remain focused on goals that are tied to specific physiological processes. However, there can often be a mismatch between advice given, and the implementation of that advice. As such, integrating clinical goals along with a person's real life environment can be challenging and, ultimately, multiple reasons may hinder an individual from fulfilling health-care advice. Thus, interventions are required to help participants identify and address barriers to integrating clinical advice. These interventions may include facilitating communication skills with health-care providers, and teaching participants skills that facilitate the implementation of change.

Poor communication and low satisfaction with the relationship between themselves and their health-care providers can negatively affect health outcomes for participants. Gaining accurate information is crucial for making informed decisions about one's health. Consequently, it is important that a person not be overwhelmed as they seek to identify key information and ask questions which may help them. Therefore, clear communication with a health-care provider is essential to help manage, understand, and subsequently adhere to a medical regimen. Even when communication is clear, individuals still face difficulties implementing lifestyle change. For some people, modifying poor health habits (such as giving up smoking or changing diet) can be extremely challenging. Reasons can include disbelief or uncertainty about medication, conflicting messages from family and friends, and barriers to implementing change. Barriers include discomfort, time limitations, and financial burdens, such as treatment costs and loss of employment. Furthermore, change may contain risks or serve to remind people of their illness. Thus, implementing changes in order to improve health is an important and complex issue for individuals with a long-term health condition.

Session Five: Goals

In session five participants are presented with knowledge and skills which reinforce their ability to be responsible for their self-care and well-being outcomes. The aim is to empower participants to access required information and to use this to make informed decisions. Exercises are designed to aid awareness of different stages of change, and aid the identification of some of the barriers people experience in making changes.

- Participants actively manage and persist in obtaining quality services from health providers by strengthening their sense of participation during interactions with health-care providers.
- Participants gain skills that enable them to form collaborative relationships with health-care providers which enhance their therapeutic outcomes.

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- Participants examine their health knowledge and behaviours, and consider recommended changes.
- Participants become more aware of personal barriers that may prevent them from implementing health-care advice.
- Strengthen participant awareness of the change process and address potential barriers to change to increase the likelihood of preparedness to change.

Session Five: Clinicians Tasks

- Place emphasis on the participant aiming to become more knowledgeable over time about their health condition and more self-efficacious in their treatment management.
- Remain curious, listen, and proceed at the pace of participants. Offer reassurance and encourage participants to feel that they have choices and are able to determine positive outcomes.
- Acknowledge that health-care regimens can be extremely complex, and that participant resources may be very limited. Be empathetic and recognise that participants may have several significant factors impacting on their ability to implement change and action.
- Ensure that participants understand that the clinicians are providing information, not medical treatment. Any changes in medication usage or lifestyle should always and only be implemented under the advice of a medical practitioner.

Session Five: Materials

- A white board and whiteboard markers.
- Extra work books.
- Name tags for participants. Collect at the end of each session.
- Extra paper and pens.
- Psychometric tools. ORS, HADS.
- Ensure ample supplies of writing material are available.
- Beverages for the break, for example, tea and coffee supplies.

Session Five: Outline

- Welcome and introduction.
- Structured group joining exercise: Stranded on a deserted island.
- Feedback on the previous week's events.
- Therapeutic intervention: Communicating with health professionals.

- Therapeutic intervention: Health-care system hints.
- Therapeutic intervention: Stages of change.
- Homework and session wrap up. Administration of Psychometric tools.

Session Five: Exercises

Exercise 1: Welcome (5 minutes)

Take a moment to introduce today's session.

Sample Dialogue for Exercise 1:

Welcome everyone. Today's session will emphasize and explore how we can get the best out of our time and interaction with health care providers, which will enable us to receive quality care. In the second part of the session we will look at a particular model which we can use to help us think about change in our daily lives. Often we know what has been recommended and we are willing to put it into practice, yet we still struggle to do so. So we will look at this further in the second part of the session. But first we will begin with a group exercise and then next we will review homework from last week.

Exercise 2: Structured Group Exercise Stranded on a Deserted Island (10 minutes)

Direct the participants to page 21 of the individual workbook.

(Next Paragraph is Repeated Manual Instructions).

The purpose of the structured group exercise at the start of each session is to enable the participants a point of entry and time to connect into the group from the previous week. Clinicians should join in as it aids in building a supportive and meaningful environment. The participants also become accustomed to sharing information and details.

Sample Dialogue for Exercise 2:

Divide participants in to small groups with at least two or three people in each group. Imagine you are stranded together on a deserted isolated island. If you knew ahead of time that there was a chance you might be stranded, what 5 items would you as a group have brought along? You are only allowed 5 items per group. List down what those items would be, and then later when we come back together, you need to tell us why you chose those items. How does this relate to working with and receiving advice from health professionals?

Give the group an opportunity to discuss what occurred. The purpose of this exercise is to learn about each other's values and problem solving styles which promotes teamwork. How effective were participants in promoting their ideas and thoughts to someone else?

This exercise helps sets the stage for the next activity which targets developing a relationship with a health team for beneficial long-term health outcomes.

Exercise 3: Feedback on the Previous Week's Homework (10 minutes)

(Next Paragraph is Repeated Manual Instructions).

Brain Storm

At this point it is important to lead and control the group in a manner which aids focus in a helpful and beneficial way. Importantly, participants who are able to adapt negative views and have more benevolent feelings toward their long term illness and their current situation may have better outcomes than participants who retain rigid or firm thinking. Amplify, restate or reframe responses as necessary.

Amplifying Change

Encourage the participants with the knowledge that these opportunities occurred outside of therapy and originate from the participant themselves, rather than by chance or luck. Link the participant actions to their experiences.

Restate or reframe

Restate or reframe negative comments by emphasising descriptions of the same situation in a positive manner. For example if they comment they had a bad week because of their health condition, ask if there was a time during their week when they did not notice their condition. Emphasise positive change which may have occurred over the previous week. What have they attempted, discovered or seen has happened that is positive change?

Sample Dialogue for Exercise 3:

Last week we used Biofeedback, which showed the positive impact we can have on our bodies when we relax. How did you get on managing all of the relaxation including breathing, imagery, sunlight, and positive experience exercises that we have practised in the last two sessions? Which exercise(s) do you prefer? How have you managed to continue this week despite difficulties? What has worked for you over the week? What is better?

Exercise 4: Therapeutic Intervention Communicating with Health Care Providers (30 minutes total)

Direct the participants to page 21 of the individual workbook.

Satisfaction with a health-care provider is a predictor of treatment adherence. Adherence is more likely if participants perceive the health-care provider as warm, caring, and someone who answers questions. Participants are also more likely to follow instructions if a provider does not assume treatment adherence will occur but, rather, takes time to understand barriers participants may face in following directions. Complex, long-term treatments, with multiple behaviours required to sustain wellness, are more difficult to adhere to. Most frequently, however, such treatments are necessary for ensuring survival.

Sample Dialogue for Exercise 4:

It can be challenging to face some health care professionals, and deal with the health care system. Unfamiliar medical terms, a fear of feeling silly or taking up a professional's time, can be just a few of the barriers some people face which prevent open communication with health care providers. Providers sometimes seem inattentive, impersonal and rush through appointments consequently leaving little time to discuss options, or explain things fully, especially as visits often last only 10-15 minutes.

In this part of the session, we want to focus on making optimal use of the time you have with health care professionals despite the difficulties you may encounter. To do this, we are going to consider the acronym P.A.R.T. This stands for Prepare, Ask, Repeat and Take Action (Lorig, Holman, Sobel, Laurent, Gonzales, & Minor, 2006).

**Whiteboard Exercise:
Clinician to the whole group****Sample Dialogue for Exercise 4 continued:**

Prepare: think about an appointment that you might have with a health professional soon. Preparing means thinking about what your main concerns are and taking some time to write a list. Not only does it help you to remember, but it helps to prioritise your main one or two concerns or symptoms. Time will limit the number of issues a health professional can adequately cover in the available appointment time, therefore mention them at the start of the appointment. Tell your health provider details such as if your symptoms have changed and details of how your symptoms have changed. A list of your current prescriptions and doses may be important to take with you to appointments. What else may you need to tell a health care provider?

Individually**Sample Dialogue for Exercise 4 continued:**

Write a list about your main concerns that you would take to a health provider.

Clinician to the whole group**Sample Dialogue for Exercise 4 continued:**

Ask: The second part of the acronym is to ask. Ask questions. Questions that begin with why and what are more likely to get a fuller explanation. This is because they are open questions and require a fuller answer than yes or no. For example, did you have a good time yesterday? Versus what did you do yesterday? What are questions you can ask about your diagnosis, health prognosis and likely course of progression, preventions, treatment options, risks versus benefits and their consequences, follow up? What is the treatment but what also is the rationale behind the treatment?

Individually**Sample Dialogue for Exercise 4 continued:**

Take the time now to list three questions.

Clinician to the whole group

Sample Dialogue for Exercise 4 continued:

Repeat: By repeating back to the health provider key aspects of your visit as you understand it has been told to you, before you leave, provides an opportunity to clarify any ambiguity or misunderstandings. If you are unclear or are confused, ask to go over it again as these areas are often quite critical or important.

In pairs

Sample Dialogue for Exercise 4 continued:

Role play an imaginary appointment time with a health care provider including the three aspects learnt so far of Prepare, Ask and Repeat.

Clinician to the whole group

Sample Dialogue for Exercise 4 continued:

Take action: Take action by asking your health care provider for written instructions that describe the treatment such as dosage, possible side effects or contraindications, or the type and amount of exercise or dietary advice. They may be able to provide you suggestions or access to further material that you can gain knowledge from or read for more information. If you can't or won't be following the advice given to you, let your provider know as they may have alternative suggestions for you.

Ask group members to share their thoughts to the whole group.

Sample Dialogue for Exercise 4 continued:

Use prompts and other reminders such as pill packaging and calendars to list appointment times for easy recall etc. Lastly, what follow up is necessary and should another appointment be scheduled?

Pause for a break (10 Minutes)**Exercise 5: Therapeutic Intervention Health Care System Hints (10 minutes)**

Direct the participants to page 23 of the individual workbook.

Dealing with a complex and busy health-care system has become a reality for many people.

Ask group members to share their thoughts to the whole group.

Sample Dialogue for Exercise 5:

What hints do you have for dealing with appointments and services?

- If you are finding it frustrating waiting for an appointment, take the first available appointment but also ask is there a way you could fill a cancellation if one became available?

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- If you are seeing multiple providers, ensure they have received information from each other and that this is present in your file notes. In NZ you are entitled to view your notes. Have you read or seen your health care notes?
- What are some practical ideas? Fill scripts a week or two ahead to avoid running out of medication. Phone ahead to see if provider is on time with their appointments or running late, to avoid having long wait room delays. Asking for a longer appointment if you require more time to be seen. What other system short cuts can you think of?
- How can you use your own knowledge and expertise, as you may be very knowledgeable about your condition?
- What is the source of your internet information and where did you hear about it? Is it well researched and factual or hearsay? Were the people mentioned in the article similar to you? Could something else have caused their improvement? Will following layman's advice cause any possible damage?

Exercise 6: Therapeutic Intervention Stages of Change Model (DiClemente, 1999) (25 minutes)

Direct the participants to page 23 of the individual workbook.

Clinician to the whole group

Sample Dialogue for Exercise 6:

We've looked at ways to improve or increase effective communication with health professionals, now we are going to discuss a strategy called the Stages of Change Model. The Stages of Change Model has been found to be an effective tool for understanding why people can face difficulties trying to change habits which affect a broad range of health issues including smoking, diet, taking medication, increasing exercise, alcohol and drug problems.

Basically the Stages of Change Model recognises that change does not happen all at once. Instead individuals go through at their own pace a number of different steps or stages. At each phase there are different decisions to make which relate specifically to that stage. For some people moving from each stage to the next one can take from a short period of time such as days or weeks, or it may take longer. Long term changes are a decision that only an individual can make and it cannot be imposed by someone else. Understanding what happens in each stage can help us to understand why it can be difficult to make necessary changes, or why we may not want to make changes at all, despite receiving advice that changes are needed.

Whiteboard Exercise: The Stages of Change

The stages of change are:

- Pre-contemplation (Not recognising a problem exists and that it needs to be changed)
- Contemplation (Recognising a problem exists but unsure if a change can happen)
- Preparation/Determination (Getting ready to change)
- Action/Willpower (Changing and addressing the problem)

- Maintenance (Maintaining the change)
- Relapse (Returning to old patterns of behaviour and giving up on the new changes)

Sample Dialogue for Exercise 6 continued:

Stage One: Pre-contemplation

In the pre-contemplation stage, people tend to be defensive about their current habit(s) and are not thinking seriously about changing or receiving help to change. There is a lack of acknowledging the existence of a problem.

Stage Two: Contemplation

In the contemplation stage individuals are likely to think more about their problems and the consequences or cost of their problems. At this stage, individuals may be more open to receiving information about their problem. However, although they consider the possibility of changing, they remain hesitant and ambivalent about change and may feel trapped. While they may think about the negative aspects of their habit, the positive affects continue to outweigh the bad effects. There are doubts that they will benefit long term from change. The kind of talk a person uses at this time is centred on having a desire for change.

Stage Three: Preparation/Determination

In the preparation/determination stage, individuals commit to make a change in their lives. Steps may be taken to find out what strategies or help or resources are available to help them change their behaviour. Often this stage is ignored or skipped as individuals try to take direct action and move from the contemplation stage and into direct action. There may be a lack of understanding and awareness of what it will actually take to make necessary major lifestyle changes. The kind of talk a person uses at this time is centred on having ability or being capable of change.

Stage Four: Action/Willpower

At this point overt efforts are made, which usually depends on willpower. This stage is exemplified by an inner belief that an individual has the ability to change their behaviour and address their problem. They take specific steps and use a variety of techniques or resources to change their problems. Often rewards are used to sustain motivation. Help from other people are often sought, and plans are developed to help deal with obstacles. However, relapse can occur or it is possible to continue to progress through the stages. The kind of talk a person uses at this time is centred around having reasons or specific arguments on why they should change.

Stage Five: Maintenance

Maintenance involves being able to successfully avoid any temptations to return to a bad habit. An important feature of this stage is that individuals often notice how much progress they have made. This period often includes learning new skills which help to avoid relapse including forward planning and prepared coping strategies which anticipate obstacles in advance. There is a sense that it can take time to bring change, but that it remains worthwhile and of benefit to them to adapt to new changes. Individuals are patient and allow themselves time to adjust to new patterns even though they may have thoughts of relapse they resist the temptation. The kind of talk a person uses at this time is centred on certainty of change or about specific action that has been taken.

Ask Group members to share their thoughts with the whole group.

Split into two groups with a therapist in each group.

Sample Dialogue for Exercise 6 continued:

How do you relate to this model? Does this model make sense to you? Are there changes you have made in your life which have been recommended to you, or you have been thinking about making, or that you would like to make?

Discuss these in your group.

Clinicians should decide whether it is prudent to remain in the group or allow participants to discuss on their own.

Sample Dialogue for Exercise 6 continued:

How does this affect you?

How does change appear for the participant? What changes do they want to make?

How have other people familiar to the participants been able to make changes?

What are some of the benefits and disadvantages of making changes?

If we consider again the contemplative and planning stages of change, from the stages of changes model; what are some of the difficulties which you might encounter or face when you are thinking about or preparing to make a change in your life? Use some of the examples you have identified in your group discussion, such as, negative emotions, conflict, social isolation, social pressure, cravings.

If we consider again the maintenance stage of change; what are some of the difficulties which you might encounter or face when you are trying to keep up your new habits? Use some of the examples you have identified in your group discussion

How do you avoid temptation?

Are there specific instances where there is a problem?

Clinician to the whole group

Sample Dialogue for Exercise 6 continued:

Relapse

Along the way to permanent change or reduction of a habit, most people experience relapse. Relapse is common, and can include feelings of disappointment and despair as well as feeling like a failure. While relapse can be disappointing relapse is normal. Most individuals may go through the stages of change cycle several times before they achieve long term change. To help turn a relapse into an opportunity to stay on track, analyse what happened to cause the relapse and how you could cope differently. It is important to restart the process again at preparation, action or even the maintenance stages, rather than go back to pre-contemplation and contemplation stages. Eventually though, long term maintenance is established. Can you think of a time when you relapsed? How did you deal with this? Given the discussion we have had today, how would you handle a relapse in the future?

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Homework (10 minutes)

Direct the participants to page 27 of the individual workbook.

(Next Paragraph is Repeated Manual Instructions).

Wind-down and summarise the session. Encourage participants by pointing out that they have accomplished a great deal of work today. The focus is on providing the participants with support to transfer work from in the session to carrying out interventions at home. Specific relevant compliments, or positive statements which target genuine attempts to set change in place, help to do this. Using the intervention for homework is a way of further encouraging participants to be creative, curious and open to new ideas.

Sample Dialogue for Exercise 7:

Look at and complete P.A.R.T. with any additional information or ideas you may have. Consider the stages of change model, and where you have identified you currently are in relation to the model on one of the areas you have identified today. Write it down. What would it take for you to move further in the direction of change you would like to make for yourself?

Hand out psychometric tests to the group and have participants fill out and return them (10 minutes).

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Session Six: Building Support

Contemporary chronic health research has placed an emphasis on how individuals may remain psychologically healthy, and has also extensively examined the role of social support. Session six emphasizes the importance of social support in the lives of participants following the completion of the group. The session also reviews the topics, ideas, and skills discussed and implemented over the course of all the sessions.

Session Six: Goals

The focus of session six is on enabling participants to enhance affirmative social support in their lives. Exercises are designed to model and rehearse practical skills which can be implemented into participants daily lives.

- Participants recognise that increasing worthwhile social support aids quality of life and life satisfaction.
- Participants acknowledge an awareness of how social support can be helpful, and attempt to remove social barriers that prevent access or participation in desired and meaningful activities.
- Participants gain increased awareness of the need to be responsible for their lives. On completion of the session, participants will be able to focus on real life issues and work on attempts at developing effective plans based on the strengths and skills they have learnt or identified from attending the group.
- Enhance acceptance and tolerance of being able to live with a long-term health condition or situation caused by a health condition, and to facilitate a more positive outlook on life and well-being.
- Participants reflect and consider the value of having attended the group treatment programme.

Session Six: Clinicians Tasks

- Explain how high quality social support both protects and promotes the health of individuals. Ensure that the participants understand that effective social support is not based on quantity, but on the quality of the relationship.
- Highlight how long-term health conditions may also generate new social support opportunities and contact with other people and care providers in the community.
- Maintain optimism in the presence of participants who may be experiencing apathy or are slow to bring about personal change.
- Prominently encourage discussions that enable participants to think for themselves, formulate their own insight, and increase coping skills.
- Be mindful of dealing with participant emotions that may accompany this session, especially emotions stirred by the thought of separating from the group.

Session Six: Materials

- A white board and whiteboard markers.
- Extra work books.
- Name tags for participants. Collect at the end of each session.
- Extra paper and pens.
- Psychometric tools. ORS, HADS, SF12.
- Ensure ample supplies of writing material are available.
- Graduation certificates for participants.
- Healthy food for end of group celebration.
- Beverages for the break, for example, tea and coffee supplies.

Session Six: Outline

- Welcome and introduction.
- Structured group joining exercise: Review of the sessions
- Feedback on the previous Week's events.
- Therapeutic intervention: Assessing and developing Social Support.
- Therapeutic intervention: Social support role play.
- Therapeutic intervention: Positive changes and last thoughts.
- Presentation of certificates and celebration.
- Administration of psychometric tools.

Session Six: Exercises**Exercise 1: Welcome (5 minutes)**

Direct the participants to page 28 of the individual workbook.

Start the session with a welcome and personal introduction.

Sample Dialogue for Exercise 1:

Hello everyone. Welcome to the last session of the Health Well-being group. Over the course of this group we have covered a lot of ground and looked at a number of issues which are a result of living with a long term or chronic illness. We have also learnt some new skills along the way. Today will focus on some of the skills and strengths you have identified and implemented over the last few weeks. We will also look at social support, and how you can use the benefits of the social support you have received by being here in the group and apply it to other areas.

Exercise 2: Structured Group Exercise Review of the Sessions (20 minutes)

Direct the participants to page 28 of the individual workbook.

Split up into two or more groups (depending on participant numbers). Divide the sessions from the last five weeks equally among the groups for review. Allow the participants a few minutes to go back over their notes and remind each other what has

occurred. Then ask each group to prepare a short summary of what happened in the sessions they covered, for feedback to the other groups.

What have you learned?

What have they been able to transfer and apply to life outside of the group?

Exercise 3: Feedback on the Previous Week's Events (10 minutes)

Direct the participants to page 28 of the individual workbook.

(Next Paragraph is Repeated Manual Instructions).

Brainstorm

At this point it is important to lead and control the group in a manner which aids focus in a helpful and beneficial way. Importantly, participants who are able to adapt negative views and have more benevolent feelings toward their long term illness and their current situation may have better outcomes than participants who retain rigid or firm thinking. Amplify, restate or reframe responses as necessary.

Amplifying Change

Encourage participants with the knowledge these opportunities occurred outside of therapy. They originate from the participants themselves, rather than chance or luck being the reason for events. Link participant actions to their experiences.

Restate or reframe

Restate or reframe negative comments by emphasising descriptions of the same situation in a positive manner. For example if they comment they had a bad week because of their health condition, ask if there was a time during their week when they did not notice their condition. Emphasize positive experience which may have occurred over the previous week. What have they attempted, discovered or seen has happened that is positive?

Sample Dialogue for Exercise 3:

Last week we looked at P.A.R.T and at the Stages of Change Model

How have you managed to implement these techniques? What positive change has occurred in your lives over the previous week? What have you attempted, discovered, or seen happen that is a positive change?

How have you managed to continue this week despite difficulties?

What has worked for you over the week? What is better?

Exercise 4: Therapeutic Intervention Assessing and Developing Social Support (10 minutes)

Direct the participants to page 28 of the individual workbook.

The purpose of this exercise is to identify existing social support, where and how to access social support, and to assess the quality of social support. Severe life events such as a chronic health condition can lead to a deterioration of social support networks and perceived social support.

White Board exercise

Have the participants write down their own thoughts first on a sheet of paper, then share as a white board exercise.

Sample Dialogue for Exercise 4:

The Biopsychosocial model highlights social environments and social systems can impact on a person's health. For example, high levels of good social support have been found to positively impact on the immune, neuroendocrine, and cardiovascular systems. For the first part of today's session we will look at the topic of social support. There are many ways social support can occur, whether it is from friends, colleagues, neighbours, acquaintances or family. Social support can be defined as feelings of connectedness and belonging to people around us. Social support includes many concepts like emotional support, physical help or other types of assistance in times of need. Good social support can have a positive impact on one's health. Even by participating in a group such as this, and having the ability to be to share common issues and concerns can help. It highlights you are not isolated or alone in your situation. Having good social support around you can help buffer the impact of distress and some of the daily hassles you experience. It can help compensate for all types or manner of loss. Another effect good social support can have is it lessens the frequency of negative health events, such as lowering cholesterol levels and other physical symptoms. It can also lessen the rates of depression associated with chronic health conditions.

1. What social support the participants believe is available to them, such as family or friends or community support?
2. What is their relationship like with these people? How do they describe it in their own words?
3. What support do they think they need such as emotional support, understanding, affection, physical or material support?
4. Where do you go when you feel overwhelmed?
5. Where did you go for support before in times gone by?
6. What has been the most helpful support you have received?
7. Why is social support important?
8. What is the difference between useful social support and social support which is not useful?

Sample Dialogue for Exercise 4 continued: (10 minutes)

Over the last five sessions, we have had the opportunity to meet new people, learn new ideas and skills from each other. One benefit is that it provides an opportunity to socialise and gain support with people who may encounter similar issues. However, valuable benefits are found in many groups and it is possible to increase and build social support comparable to what you have experienced here by meeting other people through an enjoyable activity or hobby. As well as social support, activities can help divert attention for a short period of time, especially if the activity involves active participation. Pastimes or hobbies add another facet to our identity which can help us to form new relationships and social support with other people on common ground. Activities also have the added benefit of increasing the sense of self-esteem, creativity and can also give us a sense of control and accomplishment. There are many examples of people in the community who manage to remain active and enjoy the benefits gained from social support despite having a health condition or physical disability. The purpose of socialising and enjoying a hobby though must be for relaxation and enjoyment, and should not cause undue stress, such as being in a group which experiences continuous conflict.

There are different kinds of support and various sources of support. Spouse/partner, children, other relatives, close friends, co-workers, community or neighbourhood groups, professions or service providers, special groups, churches, etc.

Pause for a break (10 Minutes)**Exercise 5: Therapeutic Intervention How to Access Social Support. Role Play (20 minutes)****Sample Dialogue for Exercise 5:**

During our first session as a group, we all experienced having to meet and interact with people we had not met before. Learning how to access social support and meet new people can be difficult. In new social situations we can feel easily embarrassed, or fearful about what others may think about us, even what could happen in our interactions with others. It can be hard initiating the first move and beginning a conversation with someone we may not know. We often don't know what to say, or how to find something in common with another person.

- Practice approaching someone you don't know, where you may feel socially shy or awkward.
- Practice opening lines to a conversation.
- Use active or reflective listening.
- Active or reflective listening is paraphrasing the other person's comments back to them.
- Begin by assuming the role of being a listener and try to understand what they are saying rather than concentrating on your own thoughts.
- Ask questions to clarify or improve your understanding of what is being said.
- Use minimal encouragers such as nodding or uh ha as they encourage the person to speak more.

- Identify what your position is by stating your thoughts and feelings about the situation you are discussing.

As you leave later on today, consider some of the activities you would like to do, or how you can strengthen some of your social support. Use the skills we have practiced today in a situation you have identified. We would like you to specifically take action towards doing what it was you recognised you would like to do.

Examples of conversation starters:

- Where are you from? Where do you live? How long have you lived there?
- What is your favourite sport? Sports team?
- What sports did you play in school?
- What good movies have you seen or good book you have read lately?
- Are you working? Where? How long have you been there? What did you do before that?

The key is asking open-ended questions and not questions beginning with either Do or Have. You want to learn about the other person to keep the conversation flowing.

If time allows work through a specific example which utilises these skills.

Exercise 6: Positive Changes in Response to a Chronic Illness and Last Thoughts (15 minutes)

Direct the participants to page 30 of the individual workbook.

Clinician to the whole group

Sample Dialogue for Exercise 6:

Some people experience optimism and other positive reactions as they reorder their priorities and find meaning in what they do in their everyday lives. They feel an appreciation to make the most of each day and opportunity. Others may feel inspired to put effort into relationships and are more understanding towards others. Some people had developed new interests as a direct result of their health condition, while an overall quality of life improved after their life had been reappraised.

Many individuals perceive control over what happens to them.

Many individuals have positive expectations for the future.

Many individuals have a positive view of themselves.

Many individuals have adaptive beliefs toward their mental and physical health much of the time.

Despite obvious difficulties you are always in control and able to make decisions for yourself.

What has the group experience meant to them?
Were there any turning points or highlights?

Give the group credit for the hard work and effort they put into the success of the group.

Appendix	301
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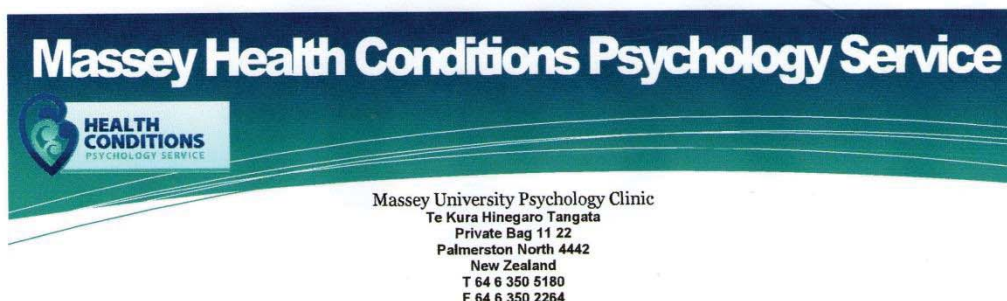
Administration of Psychometric SF`12, HADS and ORS	62
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Presentation of Certificates and Celebratory Buffet (20 minutes)	
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Appendix B Group Participation Invitation



Health Wellbeing Group

Dear

This letter is to provide you with important information about the Health Wellbeing Group which you are about to attend, run by the Massey Health Conditions Psychology Service. This a FREE service provided by Massey University Psychology Clinic in conjunction with Mid Central District Health Board. The purpose of the Health Wellbeing Group is to help people diagnosed with a long-term health condition/s and their families cope with, and adjust to, their condition and the impact this has on their lives.

As part of our service, you will receive a pack of questionnaires which will help ensure your needs are met. Please fill these out prior to coming to the group and bring them with you on the day. It is normal to feel apprehensive before attending a group and starting something new. However, we assure you that we will do our best to make you feel comfortable.

LOCATION AND TIMING OF OUR NEXT GROUP

WHERE: The Conference Meeting Room located at the Levin i-SITE Visitor Centre.

93 Oxford Street, Levin

FROM: Tuesday October 11th 2011 at 1pm - 3pm.

DURATION: The group will run for **two hours** (including a refreshment break), once a week for six weeks.

FACILITATORS: The facilitators are Maria Berrett and Sarah Malthus. Both are experienced senior clinical psychologists with expertise in working with people affected by long-term health conditions.

CONFIDENTIALITY: As a service we maintain a firm policy of confidentiality. Absolutely no information we hold about you will be passed on to another person or agency without your written and expressed consent. The only exceptions to this policy are a life threatening emergency or a court order to produce records. However, it is possible that issues which may be personal in nature arise during the sessions. We will discuss confidentiality further in person at the start of the group.

RESEARCH: Research is important to help us evaluate the effectiveness of our work, to improve our clinical service and psychological knowledge. Case material including questionnaires may be used for research or teaching purposes, but only under assurance that identifying information will not be included. You may be asked to participate in specific research projects. Such participation is voluntary, will have no bearing on the service you receive and will take place only with your expressed written permission.

If you have any further queries, please feel free to contact us at the Massey Health Conditions Psychology Service, Massey University Psychology Clinic:

Administration: Gail Shirley Phone: +64 6 3505180

Email: G.B.Shirley@massey.ac.nz

Coordinator: Maria Berrett Phone: +64 6 3569099 ext 2045

Email: M.Berrett@massey.ac.nz

Appendix C Certificate of Participation

	
CERTIFICATE OF PARTICIPATION	
This certificate is awarded to	
<i>in recognition of valuable contributions to</i>	
<i>Health Wellbeing Group</i>	
_____ Signature	_____ Date
_____ Signature	_____ Date

	
CERTIFICATE OF PARTICIPATION	
This certificate is awarded to	
<i>in recognition of valuable contributions to</i>	
<i>Health Wellbeing Group</i>	
_____ Signature	_____ Date
_____ Signature	_____ Date

Appendix D Participant Questionnaire



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

An Investigation into the Outcomes of the Health Conditions Service Group Intervention

Questionnaire Sheet

Researcher: Evelyn Aranas
Contact number 06 3569094 Extension 7165

Supervisor: Cheryl Woolley
Contact number: 06 3569-099, Ext 2076

Supervisor: Christine Stephens
Contact number: 06 3569-099, Ext 2081

Massey University Psychology Clinic Health Conditions
Contact number: 06-350 5196

Dear

I am interested in hearing about your experiences and what it was like for you to participate in the Well Being Group being run by Massey University's Palmerston North Psychology Clinic Health Conditions Service. I would like you to think about events that were important to you. As such the questions I have outlined here are designed only to stimulate our talk. Other questions may arise from our conversation or there may be things you think of and would like to mention. Overall, I would like you to tell me about what you gained from your experience of participating in the programme.

1. What was it like going to the wellbeing group for the first time?
2. What was it like going to the wellbeing group for the last time?
3. What were your main concerns prior to attending the group?
4. Were your needs met or not met by attending the group?
5. How effective do you think going to the group was in helping your situation?
6. Were you satisfied with the content of the sessions?
7. Were there any problems or difficulties that occurred in the group such as the group's composition, discussion, leadership, or format that you may have found disappointing or unproductive? If so, what were they?
8. Were the members supportive and respectful for one another?
9. What changes have occurred in your life as a result of attending the group?

Appendix E Invitation to Participate in the Research Project



AN INVITATION TO PARTICIPATE IN A RESEARCH STUDY

An Investigation into the Outcomes of the Health Conditions Service Group Intervention

The Health Conditions Service is in the process of inviting clients to take part in a study of their experience of using the Service and would like to invite you to be a volunteer. We would like to hear from as many people as possible as the Health Conditions Service is interested in the way psychological services can offer support and assistance to those with long term health conditions.

If you wish to take part in this study, the information from the brief questionnaires which Clinicians give everyone prior to the start of the group, and at the end of each group session will be used by the researcher. These forms only take a few minutes to fill out. An interview about your experiences of the service, which will last about one hour, will also be used as part of our research. Any information which personally identifies you or your name will not be used in any report or be seen by Health Conditions Service staff.

Remember that you have the right not to take part and you are not committing yourself if you return the slip.

If you do reply to our invitation to be a volunteer, more information will be posted to you. You will then be contacted by Evelyn Aranas (the Principal Researcher), to talk to you in more detail about the study, and discuss any questions you may have. If you agree to participate, an interview will be arranged for a time that suits you. Your interview would take place in a private room at the Health Conditions Service Clinic or alternatively, where appropriate, a meeting can take place in your home or in a suitable, mutually agreed venue. A \$20 fuel voucher will be provided at your interview to cover your time / travel costs.

If you are interested in participating in the study or finding out more about it, please fill out the slip below and return it to the Health Conditions Service in the Freepost envelope enclosed by

Thank you for considering this invitation.

Yours sincerely

Gail Shirley , Administrator
Health Conditions Service
Massey University
Ph: (06) 3505196

Cut Here:-----

I am considering volunteering and participating in your study. I would like you to contact me to discuss it further.

Name: -----

Address:-----

Contact Phone Number:

CellPhone Number:

Appendix F Information Sheet



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

An Investigation into the Outcomes of the Health Conditions Service Group Intervention

INFORMATION SHEET

Researcher: Evelyn Aranas
Contact number 06 3569094 Extension 7165

Supervisor: Cheryl Woolley
Contact number: 06 3569-099, Ext 2076

Supervisor: Christine Stephens
Contact number: 06 3569-099, Ext 2081

Massey University Psychology Clinic Health Conditions
Contact number: 06-350 5196

Dear

Thank you for volunteering to receive further information. My name is Evelyn Aranas and I am currently completing a Doctorate of Clinical Psychology at Massey University.

Massey University's Palmerston North Psychology Clinic is developing services that are among the first of their kind in New Zealand. The aim of this project is to examine the outcomes for participants in the Well Being Group being run by Health Conditions Service at Massey University's Palmerston North Psychology Clinic.

To do this, I would like to informally interview some people about what effect attending the group has had. Alongside the interviews, all participants in the well being group were given forms prior to starting the group and at the end of each session. The research will involve using data from these forms. If you choose to take part, I will send out a list of questions asking about your experience of the service a week before the interview. You will not be asked personal questions regarding specific health or medical issues.

The interview will take place either at the Massey University Psychology Clinic, or at a place and time convenient to you, such as your home or in a mutually agreed location. It will last no longer than 60 minutes and with your permission, the interview will be recorded.

You can ask for the recorder to be turned off at any time. No information, which would identify you, would be used at any time. Only I will know your identity. Any personal details, including your name, will remain confidential. If you wish, you may choose a

pseudonym to use. A \$20 fuel voucher will be provided at your interview to cover your time / travel costs.

I will store all interview and research material in a locked filing cabinet at Massey University, which is only accessible to myself. Once I have transcribed the interview, I will send you a copy. You can modify, add or remove any information from the transcript. I will provide a prepaid envelope for transcripts if you wish to return it. If it has not been returned within 3 weeks I will continue with analysis of the transcript as I originally supplied it to you. At the end of the study I will also send you a brief summary of the results. All tapes, transcripts and data will be destroyed after 10 years

If you choose to take part, you have the right to refuse to answer any questions. You have the right to ask for the recorder to be switched off at any time during the interview. If you do agree to take part, you can withdraw from the study at any time without having to give a reason and this will in no way affect your future or continuing health care. You have the right to stop the interview should you feel any distress during the interview.

For this study we are not routinely letting your General Practitioner know about your participation, but are happy to do so should you wish.

If you have any queries about the research project or questions, please do not hesitate to contact me or my supervisors Cheryl Woolley and Christine Stephens.

This project has received ethical approval from the National Health and Disability Ethics Committee (Central):

Central Ethics Committee

C/- Ministry of Health

2nd Floor, 1-3 The Terrace

PO Box 5013, Wellington central_ethicscommittee@moh.govt.nz

If you have any queries about your rights as when you take part in this study, you may wish to contact the Health and Disability Advocate: telephone 0800 42 36 38 (4 ADNET)

Thank you very much for your time.

Evelyn Aranas
Researcher

Appendix G Consent Form



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

Request for an interpreter

English	I wish to have an interpreter	Yes	No
Deaf	I wish to have a NZ sign language interpreter	Yes	No
	E hiahia ana ahau ki tetahi kaiwaka Maori?kaiwaka pakeha		
Maori	korero	Ae	Kao
Cook Island			
Maori	Ka inangaro au i tetahi tangata uri reo	Ae	Kare
Fijian	Au gadreva me dua e vakadewa vosa vei au	Io	Sega
Nuiean	Fai manako au ke fakaaoga e taha tagata fakahokohoko kupu	E	Naki
Samoan	Ou te mana'o ia i ai se fa'amatala upu	loe	Leai
	Ko au e fofou ki he tino ke fakaliliu te gagana Peletania ki na		
Tokelaun	gagana o na motu o te Pahefika	loe	Leai
Tongan	Oku ou fiema'u ha fakatonulea	Io	Ikai

I have read and understand the Information Sheet dated ____ for volunteers taking part in the study designed to investigate the outcome of a group intervention for health conditions. I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study. I have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to decline to answer any particular questions. I understand taking part in this study is voluntary and I have the right to withdraw from the study at any time. This will in no way affect my continuing or future health care.

I understand my participation in this study is confidential and that no material that could identify me will be used in any reports on this study. I have had time to consider whether to take part in the study.

I agree to participate in this study under the conditions set out in the Information Sheet.
I agree/do not agree to the use of data from my psychometric tests and/or questionnaires
I agree/do not agree to my interview being digitally audio taped.
I wish to receive a copy of the results yes/no (please circle)
I wish/do not wish for my General Practitioner know about my participation in the study

I _____ (full name) hereby consent to take part in this study.

Signature:

Date:

**Name of
Researcher** Evelyn Aranas

**Contact Phone
Number** 06 3569094 Extension 7165

**Project Explained
by**

Project Role

Signature:

Date

Supervisor: Cheryl Woolley
Contact number: 06 3569-099, Ext 2076

Supervisor: Christine Stephens
Contact number: 06 3569-099, Ext 2081

Massey University Psychology Clinic Health Conditions
Contact number: 06-350 5196

Appendix H Release of Transcript**An Investigation into the Outcomes of the Health Conditions Service
Group Intervention****AUTHORITY FOR THE RELEASE OF TRANSCRIPTS**

**Researcher: Evelyn Aranas Contact number 06 3569094 Extension
7165**

Supervisor: Cheryl Woolley Contact number: 06 3569-099, Ext 2076

**Supervisor: Christine Stephens Contact number: 06 3569-099, Ext
2081**

**Massey University Psychology Clinic Health Conditions Contact
number: 06-350 5196**

This form will be held for a period of five (5) years

I understand I will have the opportunity to read and amend the transcript of the interview/s conducted with me. I understand that failure on my behalf to return the transcript within three weeks of my receiving it gives the researcher permission to proceed with her project.

I agree that the edited transcript and extracts from this may be used by the researcher in reports and publications arising from the research.

Signature

Date

Full Name

Te Kūnenga
ki Pūrehuroa

School of Psychology - Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442, New Zealand T +64 6 356 9099 extn 2040 F +64 6 350 5673
<http://psychology.massey.ac.nz>

Appendix I Clinicians' Questions

Development of the Manual

1. Can you describe for me your experience of developing the manuals for the service?
2. What aspects of the manual (eg therapeutically, layout, theoretical underpinnings) did you suggest for inclusion?
3. Could you describe for me the evaluation processes you followed in the evaluation of the manual as they were being written?
4. Could you describe for me the evaluation processes you followed in the evaluation of the manual as they were being implemented in the groups?
5. Did any sessions stand out as going particularly well and if so what was it about?
6. Were there any sessions with hindsight you felt needed changing? If so why?

Clinicians Personal Experiences of the Manual and Groups

7. What aspects of the manual did you feel worked well and didn't work well? Eg such as clinicians dialogue, homework etc.
8. Have you run groups before?
9. What is it like for you to run a group?
10. How did you evaluate client's responses and impact of the therapy in each session and overall? Were the individual session objectives met?
11. Can you describe the therapeutic relationship between yourself and the group as a whole and as individuals?
12. Were the groups cohesive? Did they engage with each other? Can you give some examples? What in particular did you notice which confirmed your previous comments?
13. What do you think clients got out of the groups?
14. Were there times where you felt there were potential conflicts in the group? What did you do to prevent this happening?

Group Therapy in the Health Conditions Service

15. What is the difference between running a group in health conditions service versus other groups you may have run?
16. What role does having group therapy play in the service prior to running the groups and now?
17. What specific problems did you have with running the group? What are the barriers that exist to prevent further groups occurring?
18. What would you like to see as far as group work occurring in the service?

Appendix J Thematic Map

A Thematic Map of the Analysis

Clinicians' Responses

Becoming a Group Facilitator

- Learning New Skills

Preparing for the Session

Meeting the Participants' Individual Needs

- The Therapeutic Alliance in a Group Setting

Managing the Group

- Getting People Involved
- Reining People In
- Governing the Sessions

Evaluating the Session

Participants' Responses

Initial Experiences of Joining the Group

- Feeling apprehensive
- What it was really like
- Better off than others

The Influence of Experiencing Group Support

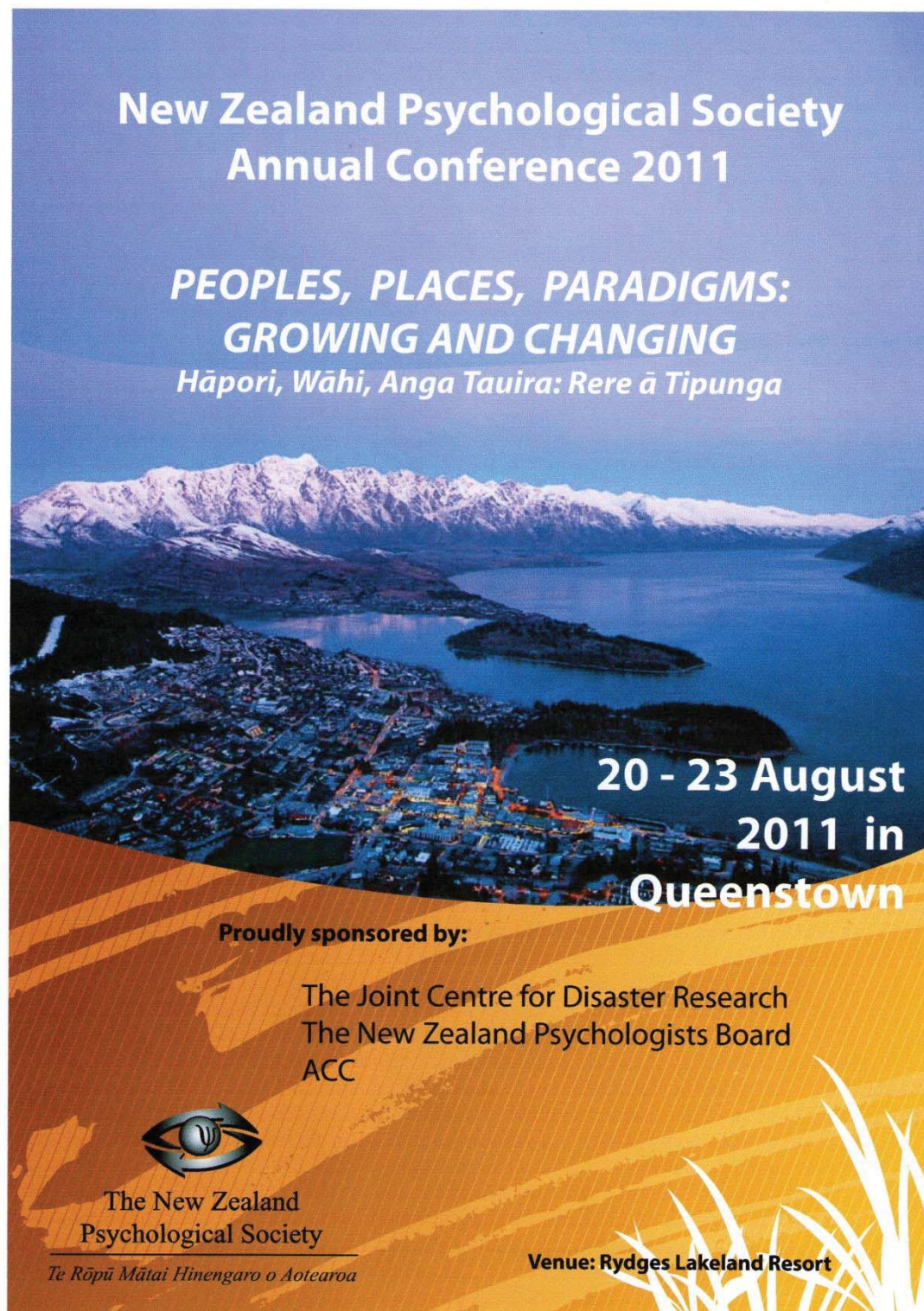
- I am not alone
- Others need to try harder
- Others may have got more out of the group

Improved Relationships with Health Professionals

Using the Therapy

- Denial of illness

**Appendix K New Zealand Psychological Society
Annual Conference Queenstown**




**New Zealand Psychological Society
Annual Conference 2011**

***PEOPLES, PLACES, PARADIGMS:
GROWING AND CHANGING***
Hāpori, Wāhi, Anga Tauira: Rere ā Tipunga

**20 - 23 August
2011 in
Queenstown**

Proudly sponsored by:

The Joint Centre for Disaster Research
The New Zealand Psychologists Board
ACC


**The New Zealand
Psychological Society**
Te Rōpū Mātai Hinengaro o Aotearoa

Venue: Rydges Lakeland Resort

Programme & Abstracts, Sunday 21st

² School of Psychology, Massey University, Palmerston North

³ Psychology Clinic, School of Psychology, Massey University, Palmerston North

⁴ Psychology Clinic, School of Psychology, Massey University, Wellington

Cancer can have a significant psychological impact on those diagnosed with cancer. The ability of psychotherapy to reduce this impact for patients and their families has been extensively studied internationally. However, New Zealand-based research in this area remains limited. The present study aimed to investigate the effectiveness of psycho-oncology interventions, provided by a New Zealand psycho-oncology service. Eighteen clients (patients/family members) of the service (intervention group) were recruited and matched for initial distress and wellbeing with patients/family members located in an area without a psycho-oncology service (control group). Wellbeing, wairua (spirituality), distress, impact and coping were measured pre- and post-therapy, and at follow-up. In addition, eight intervention group participants were interviewed to examine their experiences of cancer and the psycho-oncology service. Possible key factors influencing the effectiveness of service interventions were also investigated. The results showed that participants who had access to the psycho-oncology service showed significant improvements in all outcome measures by the end of therapy. The majority of these were maintained 3 months later. Improvements were also observed in the control group. Results will be discussed within the context of the five key themes identified as most beneficial.

p_croy@yahoo.com

5.30pm

Will the Needle Make Me Bleed to Death? Cognitions of Chronically Ill Children

J A. McIvor, J E. Taylor and K J. Ross
School of Psychology, Massey University

Chronic childhood illnesses can have profound psychological implications for children and their families, particularly when necessary treatment is associated with distress, as is the case with needle injections. Treatment of needle-related distress in children has included physical restraint and sedation, which can result in increased anxiety, avoidance of healthcare, and non-compliance with medical treatment regimes. The few reported psychological interventions have focused on behavioural approaches, with no attention to the influence of cognitions despite their role in the onset and maintenance of needle-related distress. Parents also influence child distress and coping during needle injections, although they have often been excluded as active participants in therapy. The aim of this study was to manualise and evaluate a brief cognitive-behavioural therapy for chronically ill children experiencing needle-related distress that incorporates

cognitive components and carer involvement. A single subject design with multiple baselines across participants was used to evaluate the therapy with six children aged to 12.

mcivormassey@gmail

6.00pm

The Development of a Manualised Treatment Intervention for Clients with Chronic Health Conditions

Evelyn Aranas¹, Cheryl Woolley², Christine Stephens², and Maria Berrett³

¹ Doctor of Clinical Psychology candidate, School of Psychology, Massey University

² School of Psychology, Massey University, Palmerston North

³ Psychology Clinic, School of Psychology, Massey University, Palmerston North

The New Zealand health system faces increasing challenges to provide psychological interventions which have been shown to improve quality of life for clients affected by chronic illnesses. A MidCentral District Health Board Massey University Palmerston North Psychology Clinic initiative established the Health Conditions Psychology Service (HCPS) which offers individual therapy. However, current demand outstrips service resources, thus potentially prolonging suffering. To provide for more efficient treatment, a six session group manualised programme for a heterogeneous population with a range of chronic illnesses has been developed. Studies describing and evaluating group therapy for chronic illness treatment in a naturalistic clinical setting are scarce. This paper describes the development of the Massey University manualised programme and the preliminary results from a pilot study. A mixed quantitative and qualitative approach investigated programme delivery and treatment effectiveness, with quality of life and reduced distress as outcomes. Findings will be discussed within the context of treatment options for delivery in an applied clinical setting.

bobandev@slingshot.c

Earthquake response & recovery continued

3.00pm - 6.30pm - Remarkables level 4

3.00pm

Post-Earthquake Psychological Resilience: Positive Effects of Micronutrients on Depression, Anxiety and Stress

Neville Blampied, Julia Rucklidge, Rachel Harris
[all University of Canterbury]

The September, 2010 earthquake in Christchurch provided an opportunity to study earthquake after-effects where death and injury were absent. It created a

Appendix L New Zealand Psychological Conference Nelson

The New Zealand Psychological Society
Te Rōpū Mātai Hinengaro o Aotearoa


New Zealand Psychological Society Annual Conference


Ka tū, ka oho - Te matai hinengaro me te ao hou
Psychology in a Changing World

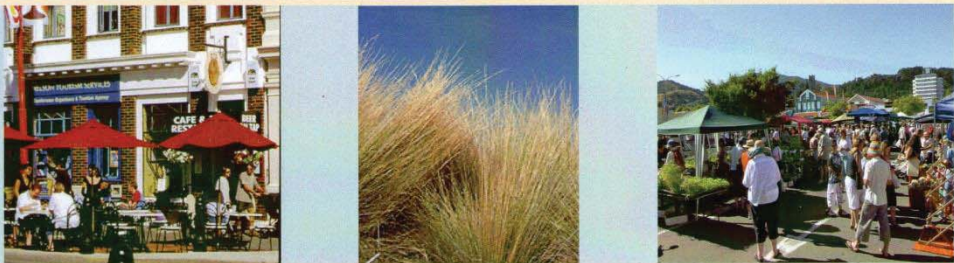
29 August - 1 September 2014
Rutherford Hotel, Nelson

Proudly Sponsored by:

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PREVENTION CARE RECOVERY
Te Kaporehanga Awhina Hunga Whara

 **PSYCHOLOGISTS BOARD**
Te Poari Kaimātai Hinengaro
o Aotearoa



Programme & Abstracts, Saturday 30th

S
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Y

working with different client populations.

11.30am

The expected course of change for clients undertaking Cognitive Behavioural Therapy as predicted by experienced and novice clinicians

Amber Fletcher, Doctor of Clinical Psychology Candidate, School of Psychology, Massey University, Palmerston North

Ian Evans, Professor Emeritus, School of Psychology, Massey University, Wellington

In response to an increasing amount of emerging literature regarding patterns of client change, the current study investigated expectations of both novice and experienced clinicians, when predicting patterns of change for clients undertaking cognitive behaviour therapy for common clinical disorders. Participants were asked to make predictions of client status following each session based on measures evaluating behaviour, mood, and clinical symptoms, to see if clinicians expected change to reflect simple, steady, linear improvement, or whether some other pattern was predicted. Whether or not clinicians were sensitive to possible process influences, such as commitment to therapy or increased insight, and how such concepts impacted on client change were also addressed. It was anticipated that this study would provide insights into needs for training and exposure to more complex ideas about the nature of change and the value of session-by-session monitoring of clients.

amberfletcher6@gmail.com

12.00pm

Being a psycho-oncologist

Dr Colette Nixon, Clinical Psychologist, MidCentral District Health Board; School of Psychology, Massey University, Palmerston North

Cheryl Woolley, Senior Lecturer in Clinical Psychology, School of Psychology, Massey University, Palmerston North

Dr Don Baken, Research Coordinator, Cancer Psychology Service, Psychology Clinic, School of Psychology, Massey University, Palmerston North

This paper presents the findings from part of a larger research project involving the Massey University Psycho-Oncology Service (POS) in which factors impacting the therapeutic outcome and experiences of clients were explored. While the therapeutic experiences of clients are regularly studied, there is a dearth of research exploring the experiences of psychologists during therapy with clients. Clients experience therapy as part of a dyadic relationship with a clinician and therefore, in order to provide a more complete study of the therapeutic process, it was felt essential to explore the therapy experience with clients from the clinicians' paradigm. Four clinical psychologists working in POS were interviewed about their thoughts, feelings and perceptions of their work. Through thematic analysis two main themes emerged of "Connections" and "Challenges".

nixons97@gmail.com

12.30pm

Therapists' challenges in bringing therapeutic change for individuals in a therapeutic group setting

Evelyn Aranas, Doctor of Clinical Psychology Candidate, School of Psychology, Massey University, Palmerston North

Cheryl Woolley, Senior Lecturer in Clinical Psychology, School of Psychology, Massey University, Palmerston North

Christine Stephens, Professor, School of Psychology, Massey University, Palmerston North
Maria Berrett, Coordinator, Health Conditions Psychology Service, Psychology Clinic, Massey University, Palmerston North

Therapeutic groups provide one solution to offering psychological interventions in response to the demand within New Zealand for clients affected by chronic health conditions such as asthma, COPD, cardiovascular disease and diabetes. In 2011 - 2012, Massey University Psychology Clinic Health Conditions Service developed and implemented a six session group manualised programme for clients with a range of chronic illnesses. The findings in this presentation describe the qualitative results arising from thematic analysis of semi-structured interviews undertaken with clinicians implementing the programme. The findings tentatively suggest that the therapist's core practice in a therapeutic group setting differs when compared to therapy for individuals or couples and family therapy. Therapists highlighted the need to consider multiple aspects in order to be effective in meeting individuals' therapeutic needs. In addition, they need to work proactively and anticipate issues and problems which may arise within a therapeutic group setting.

bobandev@slingshot.co.nz

Health Psychology research and practice in a changing world

Chair: Iris Fontanilla

11.30am Wairau

The Institute of Health Psychology, NZPsS is pleased to host the Health Psychology Symposium at the NZPsS Nelson Conference 2014.

The principal aim of this symposium is to highlight the diversity of research and practice amongst health psychologists in a myriad of physical health settings in Aotearoa New Zealand. Moreover, the oral presentations will outline the emerging changes, innovations (such as e-therapies), and contributions of health psychology research and practice for Māori, Pacific Peoples, and New Zealanders across primary, secondary, tertiary, and community organizations.

11.30am

Does kindness matter? The case for self-compassion in health psychology

Anna Friis, Health Psychologist, PhD Candidate,