

CASE STUDY

The successful impact of adapting CBT in IAPT for people with complex long-term physical health conditions

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(Received 31 August 2019; revised 3 July 2020; accepted 3 July 2020)

Abstract

It is widely recognised that a diagnosis of a long-term physical health condition (LTC) is likely to have a significant impact on a person's mental health. This is highlighted in the *Five Year Forward View for Mental Health* (NHS England, 2016) where significant numbers of patients projected to be seen through the expansion of Improving Access to Psychological Therapies (IAPT) services are to come from within the LTC community. IAPT services offer evidence-based therapeutic interventions for common mental health issues – anxiety disorders and depression. The South East Staffordshire IAPT services have developed an integrated pathway as a Wave 2 site for the delivery of cognitive behavioural therapy (CBT) adaptations for LTC. The main themes outlined in this paper focus on the innovations and service developments of IAPT-LTC including: the importance of engagement between mental health and medical healthcare professionals, identifying the key professionals in medical healthcare to enhance engagement, extended training for clinicians with in-house continued professional development, as an extension to the National IAPT-approved top-up training for LTC, and developments in clinical supervision structures and practice, along with future developments in the field of IAPT-LTC. These themes have direct relevance to CBT practitioners working within the LTC community in IAPT services. The four contrasting case studies demonstrate how the application of CBT can successfully be adapted to condition related beliefs and behaviours, despite the complexity of the medical condition. Findings show how integrated services and engaging with medical healthcare professionals had profound benefits for the patients, IAPT therapists and medical healthcare professionals.

Key learning aims

- (1) The good practice points in the development of the IAPT-LTC pathway within South East Staffordshire IAPT services.
- (2) The successful design and implementation of the IAPT-LTC pathway within South East Staffordshire IAPT services.
- (3) The key considerations of the interaction for patients between their physical and mental health symptoms.
- (4) The application of CBT adaptations for people with complex LTCs can be effective in improving psychological wellbeing and physical condition management.

Keywords: anxiety disorders; case series; cognitive behaviour therapy; depression; IAPT; integrated pathway; long-term physical health condition; service delivery; service models

Introduction

Mental health and physical health are intrinsically linked, and the relationship between untreated depression and anxiety disorders and poor physical health is complex and bi-directional. Patients with long-term physical health conditions have an increased risk of depression or anxiety (National Collaborating Centre for Mental Health, 2018a,b). Approximately 40% of patients with a mental health condition have a co-morbid long-term physical health condition (National Collaborating Centre for Mental Health, 2018a,b). Up to 30% of patients with long-term physical health condition (LTC) and 70% with medically unexplained symptoms (MUS) also have mental health co-morbidities (National Collaborating Centre for Mental Health, 2018a,b).

The *Five Year Forward View for Mental Health* (NHS England, 2016) set out clear objectives to enable integration of mental and physical healthcare. By 2020/21, it is expected that an additional 600,000 adults with depression and anxiety disorders will have access to evidence-based (NICE-recommended) psychological therapies each year, resulting in a further 350,000 adults completing treatment. A large proportion of this expansion is occurring in IAPT services co-locating with physical health services.

South East Staffordshire IAPT Services is a Wave 2 site delivering 'IAPT-LTC' services. These include areas of respiratory disease (e.g. chronic obstructive pulmonary disease), diabetes, oncology (e.g. cancer), cardiology (e.g. heart failure), rheumatology (e.g. fibromyalgia) and MUS (e.g. chronic pain). In the first year of implementation we treated 1279 patients with a co-morbid diagnosis of an LTC out of a total of 4888 patients treated by the service in that period.

Our key aims during the implementation of IAPT-LTC pathway was to review the impact of LTC on the presentation of mental health conditions and help promote self-management of LTCs. The clinical focus was specifically to address problematic beliefs and behaviours including their level of engagement in therapy. The overall aim was to ensure that delivery of cognitive behavioural therapy (CBT) was inclusive of the LTC population.

We present four complex LTC cases which show successful recovery implementing CBT interventions via the IAPT-LTC pathway. These cases have been selected to demonstrate particularly how the application of CBT can be adapted to condition related beliefs and behaviours, despite the complexity of the medical condition.

Adaptations in CBT

Case studies

Ms A

Ms A, is a 27-year-old White British female. Aged 25, she was diagnosed with triple negative breast cancer. Following six courses of chemotherapy and a double mastectomy, Ms A came to view herself as 'weak' for experiencing cancer, having previously seen herself as 'strong, invincible and untouchable'. This shattering of her self-identity created a crisis and a detailed assessment identified severe generalised anxiety [General Anxiety Disorder-7 assessment (GAD-7) score: 18] and depression [Patient Health Questionnaire-9 (PHQ-9) score: 20]. Formulating the impact of cancer on her core beliefs with an adaptation to the Melanie Fennell low self-esteem model helped Ms A to see how shame aroused by these beliefs underpinned her distress and avoidance, cutting off social support and pleasurable activities, whilst creating space for worrying and rumination to occupy her mind.

Behavioural experiments and cognitive restructuring were core skills during Ms A's treatment, helping to test and modify beliefs, expanding engagement with life and disrupting worrying and rumination. This enabled Ms A to build up to a key experiment, where she shared the story of her cancer journey on social media. The overwhelmingly positive response helped Ms A to reduce her shame and re-establish close, social support. This empowering experience led Ms A to explore

ways to positively use her experience to raise awareness of breast cancer in young women. Overcoming her shame and reconnecting with life helped Ms A to achieve psychological recovery by her final 19th session (PHQ-9 score: 2; GAD-7 score: 4).

Ms A's experience of shame arising from negative beliefs about the cause of cancer and the meaning for her self-identity was at the heart of her anxiety and depression and only by identifying and carefully confronting these beliefs was Ms A able to recover: 'I found my life spiralling away from me into a dark hole, where the last thing I wanted to do was leave the house. I was ashamed of becoming ill; it felt like all my fault. CBT taught me how to challenge my negative thoughts, to help me look at my strengths, to start enjoying planning for the future again and help me find my new normal'.

Ms B

Ms B is a 48-year-old White British female. Two years ago she was diagnosed with osteoarthritis, neuropathy and lumbar facet syndrome, generating chronic pain and significantly affecting her mobility, leading to loss of employment. Detailed assessment highlighted difficulties adjusting to these conditions; Ms B was pre-occupied with losses in health and functioning, leading to isolation and anxieties about coping with her physical symptoms of pain. She had previously attended a pain management course with another service and reported finding this informative but experienced a difficulty implementing techniques.

An adapted Beckian longitudinal formulation was used to develop links between physical and emotional factors and past and present experiences. This helped Ms B to recognise how her pre-occupation of losses, maintained by avoidance and overthinking, impeded her ability to integrate her health conditions and adjust her life to accommodate them. Creating time for Ms B to express her grief helped her to feel acknowledged whilst seeing how ruminating on her losses fuelled her depression. This helped her to increasingly accept, and shift her attention away from, lost activities or functioning, and identify what potential, valued activities were still possible with or without adaptations. This shift helped foster increased motivation to integrate interventions from the pain clinic in addition to new knowledge and skills such as pain 'gate theory', pacing and planning, facilitating positive, stable behavioural activation. Ms B achieved recovery from depression and anxiety within 10 sessions (PHQ-9 score: 6; GAD-7 score: 5).

Ms B reported that the personal focus of one-to-one work and the recognition of her individual experiences was a key factor in her progress: 'I am thinking differently about things since attending the sessions and doing things in a more manageable way'. Unacknowledged and unaddressed losses kept her stuck, preventing her from applying techniques acquired from previous interventions or developing new skills. This highlights the role of IAPT services in treating psychological distress, which may prevent the successful use of other medical services.

Mr C

Mr C is a 52-year-old, married, former English teacher who experienced a stroke 5 years ago, resulting in fatigue, reduced mobility, early retirement and a reliance on welfare benefits. An increase in sexual libido also followed the stroke, along with the emergence of hitherto absent same-sex desires, generating fears of rejection if shared with his wife, whilst he also suffered sexual dysfunction and reduced sexual intimacy with his partner. With a formerly active employment, social and sex life, Mr C's stroke left him feeling frustrated, powerless and helpless.

Detailed assessment highlighted severe generalised anxiety and depression [PHQ-9 score: 17; GAD-7 score: 16; Penn State Worry Questionnaire (PWSQ) score: 65], maintained by excessive worrying and rumination. An adapted Dugas and Robichaud Generalised Anxiety Disorder formulation highlighted Mr C's pre-occupation with past, present and future issues beyond his control. It helped him to see how worrying functioned as an attempt to gain control over his

life and prevent bad events from happening, whilst simultaneously avoiding powerful feelings of grief, anger and frustration about irreversible losses. Through cycles of worry management and acceptance work, Mr C gradually shifted his focus away from losses and hypothetical worries and towards addressing difficulties within his sphere of influence, such as budgeting, pacing of daily tasks, seeking community and social support and resources.

Mr C noticed a significant reduction in worrying, anxiety and fatigue and an increase in self-efficacy. He reinforced this by re-directing time and energy into valued activities and worked on the conflicts around his sexuality. Negotiating with his wife options for sexual intimacy beyond maintaining an erection or penetration, enhanced mutual sexual satisfaction, closeness and self-esteem. Mr C simultaneously explored and integrated same-sex desires by accessing online support and expressing them through erotic fiction.

After 16 sessions, Mr C's outcome measures indicated psychological recovery (PHQ-9 score: 4; GAD-7 score: 5; PWSQ score: 36), which was clearly predicated on a 'whole-person' treatment response, demonstrating the need to explore and treat the impact of the long-term condition on all aspects of his life.

Mr D

Mr D is a married man, father of two young children and a former labourer with a diagnosis and 5-year history of symptoms of multiple sclerosis (MS). He was referred by his GP following periods of treatment and work with a consultant neuropsychologist. Discussion with the GP highlighted concerns about persistent low mood, negative outlook, self-harming behaviours and little engagement with a specialist MS nurse.

Assessment highlighted moderate-severe symptoms of depression (PHQ-9 score: 16) and severe functional impact of Mr D's mood and physical health [Work and Social Adjustment Scale (WSAS) score: 34]. Having been physically active with work and leisure pursuits throughout his life, Mr D's self-perception with the deterioration of his MS was that he was 'finished' and 'weak', with children who 'will never know their real father'. Anger about his condition and its impact was self-directed with self-critical thoughts and, at times, punching himself in his body following a fall. His low mood was further reinforced by withdrawal from activities, family life and rumination.

Through cognitive restructuring, we were able to identify underlying beliefs that 'if people work hard enough, they can fix or overcome any problem'. Drawing on educational input from his work with the consultant about his condition, Mr D was able to challenge these beliefs and develop a more compassionate understanding of his symptoms and difficulties; he began to see the futility of his self-destructive behaviour and withdrawal, losing time and energy that could be spent making the most of his current health with his family. By identifying a range of values-driven activities and contributions to family life that were still possible, with or without adjustments and aids, Mr D increased his activity at home and with family. This boosted his self-image as a partner and father. As his mood improved, Mr D began to better utilise contact with his MS nurse and identify activities within the community, adapted to support people with disabilities.

At discharge, Mr D was in recovery with significant reductions in symptoms of depression (PHQ-9 score: 2) and functional impairment (WSAS score: 17). Our work highlighted the importance of clients connecting with physical health teams to access accurate medical information about their condition, which can be processed in therapy to modify inaccurate or unhelpful illness perceptions, as well as to support community integration. Liaison between therapists and health teams is also important to support a careful assessment of the client's illness perceptions and to guide effective interventions.

Overall, these case studies support the intricate relationship between physical illness and mental health and the detrimental consequences on one's view of self and the world. Forging integrated working can help patients to explore and adjust to these lifestyle changes. General

feedback from patients has suggested the importance of clinicians understanding their LTC and how its integral relationship with their depressive/anxiety symptoms contributed to the treatment and management of their physical and emotional wellbeing.

Development of IAPT-LTC pathways

The core considerations in the design and implementation of IAPT-LTC pathway broadly encompassed: the engagement of colleagues in physical health care settings, identification of the key professionals to enhance the pathway development, the national training opportunities including in-house clinical/continued professional development workshops and the implementation of these clinical skills with supportive clinical supervision. Collectively, these core developmental areas highlight the good practice points in contributing to the application of CBT adaptations for people with complex LTCs and improving psychological wellbeing and physical condition management.

Engagement

From inception our services recognised, for true integration to become reality we would have to invest in relationship building with our colleagues in physical health care settings. Case study D demonstrates how consultation with the GP about the current prognosis of the medical condition and work previously completed, i.e. by a consultant neuropsychologist (unavailable due to retirement prior to client being referred), can help synthesise the clinical information and aid collaborative treatment planning. It was crucial to identify and work with key professionals within the LTC networks to champion the role of IAPT and educate the benefits of our interventions for their patients; also of the potential impact on their own workload. To facilitate this, we paired up IAPT therapists with medical healthcare professionals (e.g. diabetes specialist nurses) where our therapists co-attended clinics. Case study A benefited from prior referral pathway development and awareness training between medical professionals and IAPT therapists. This facilitated the need for information about the effects of chemotherapy and long-term impact of a cancer diagnosis, without delay to the therapeutic treatment plan. This ‘together working’, while initially resource intensive, has proved to be a highly effective way of developing mutual insight and co-education. In conjunction with social media promotion, this initial investment has also provided transparency in the IAPT criteria to ensure appropriate referrals, encourage staff to regularly discuss patients and develop clear referral pathways.

Identification of key professionals

We acknowledged that medical healthcare professionals often experience insufficient time to explore mental health issues, and prioritise the identification and treatment of physical problems. Conversely when mental health problems are identified some still attribute these problems to an inevitable reaction to the LTC which therefore is ‘untreatable’. This became more evident in neurological cases. Fostering a relationship with a consultant neuropsychologist for case discussions, joint assessments and co-education led to highly appropriate referrals resulting in high conversion rates. Together we were able to challenge the barriers to engagement where some patients with LTCs find it hard to see the merit of psychological therapies in the context of their physical health problem or find the stigma associated with mental health issues prohibitive. A further challenge to this pathway presented when the lead consultant neuropsychologist resigned from the Trust without a replacement lead. This caused an interruption in the pathway, delaying collaborative and effective treatment planning for patients. Our solution in the interim, as illustrated in case study D, was for suitable cases to be discussed with the GP and our consultant clinical psychologist/clinical lead who had neuropsychology experience. We recognised that combined

integration with the neuropsychology service had a positive impact on patients. The long-term plan resulted in a streamline referral pathway enabling case discussions during the referral meetings.

All case studies highlight the importance of thorough examination of clients' illness perceptions in that there may be subtle misunderstandings about the condition, treatment, cause, prognosis and options/resources available. These opportunities for cognitive restructuring are important and so accessing accurate information from expert professionals is vital to help guide treatment. Subtle shifts in the perception of the client's illness can shift an attitude towards their view of themselves, current situation and future. Where these misunderstandings or gaps in knowledge are apparent, there are opportunities to support clients to make good use of physical health appointments by pro-actively gathering accurate information about their condition and their concerns, to then process within therapy.

Training

The LTC training enabled therapists to adapt standard CBT models and protocols to meet the complex and multi-faceted needs of patients with LTCs. We actively encouraged therapist input during the LTC implementation in monthly meetings to feedback our learning, progress and capture our contributions to making positive changes. This stance helped us to promote a sense of ownership and pride in our workforce. A continued professional development programme delivered by professionals in their specialist domains (e.g. consultant neuropsychologist) further enhanced therapists' understanding and knowledge base of specific LTCs. Internal senior CBT therapists delivered training on how to assess and formulate LTCs using CBT, along with CBT adaptations. Our IAPT-CORE pathway delivers evidence-based psychological therapies to adults with common mental health symptoms. Treatment modalities include CBT, eye movement desensitisation and reprocessing (EMDR), counselling for depression (CFD) and interpersonal therapy (IPT). Such training was delivered to the whole workforce as it was evident that LTCs (e.g. asthma) also featured on our IAPT-CORE pathway and can benefit from consideration in formulation and treatment planning. Adaptations to our duty supervision process have allowed for LTC cases to be discussed specifically with LTC trained supervisors to consider effective treatment planning from inception.

Clinical supervision

Clinicians were supported by a robust LTC case supervision structure where they benefit from monthly clinical supervision delivered by an experienced supervisor, with physical health psychology experience, in a group format, allowing for case discussion, reflection and shared learning. All contrasting case studies identified supervision as particularly helpful to consider during the formulation stage of therapy. The relationship between thinking patterns and behaviours with physical health conditions, is more complex and so shaping a purposeful formulation is more challenging and supervision reportedly helped to focus on targeting interventions at key thoughts and behaviours.

A further opportunity for input and support is provided by regular 'core' clinical supervision where adaptations are overlooked by senior therapists and/or consultant clinical psychologist/clinical lead. Our pathway has also demonstrated benefits not only to our patients and service but also to medical healthcare professionals, as illustrated in case A.

Future developments

NICE recommends mindfulness-based CBT workshops for patients with co-morbid relapsing depression (National Collaborating Centre for Mental Health, 2018a,b). This is a current development within our service, led by a high-intensity CBT therapist trained in mindfulness.

Our aim is to promote coping strategies for patients by encouraging self-understanding and self-care skills. This in turn will improve common mental health difficulties and how patients understand and relate to their LTC. An initial screening stage supports suitability criteria.

Future considerations for development include supervision provisions for medical healthcare professionals. This would enable improved understanding of IAPT interventions and how its implementation benefits the patient's emotional wellbeing. Consequently, this format provides an additional opportunity for medical healthcare professionals to advise on medical issues. The integration of services will improve waiting times and access to relevant and effective treatment and is awaiting evaluation.

Within our service, data are collected via IAPT minimum data sets, disorder-specific measures and the service receipt inventory (CSRI) for the IAPT-LTC pathway. First year implementation results show 77% successful recovery in patients with common mental health symptoms and complex LTCs. Further LTC-specific measures, e.g. Diabetes Distress Scales, are being considered to capture the positive improvements in the medical components of the LTC. Additional patient feedback will provide qualitative data, whilst focus groups will enhance co-education. However, we have also experienced challenges concerning the co-location of medical professional teams, leading to limitations in streamlining processes. We continue to work with our colleagues to create an environment to sustain integrated assessments and LTC workshops for patients and their families.

Conclusion

The South East Staffordshire IAPT services have developed integrated pathways to address the complex relationship between LTCs and emotional distress to improve and provide high-quality care. Our clinical cases demonstrate how CBT adaptations can achieve clinical recovery in common mental health difficulties and how one can engage in acceptance of their LTC. The application of CBT to condition related beliefs and behaviours can be effective in improving outcomes for both psychological wellbeing and potentially condition management. Future developments discussed will enhance the IAPT-LTC pathway and patients' recovery.

Acknowledgements. We would like to express our gratitude to the patients for agreeing to share their story in this case series.

Financial support. This case series received no specific grant from any funding agency, commercial or not-for-profit sectors.

Conflicts of interest. R. Panchal, B. Rich, C. Rowland, T. Ryan and S. Watts have no conflicts of interest with respect to this publication.

Ethical Statements. R. Panchal, B. Rich, C. Rowland, T. Ryan and S. Watts have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS. No ethical approval was required because this paper is a case series of four clinical cases. Patient consent was obtained in writing for their information to be anonymised for publication.

Key practice points

- (1) The importance of mental health and medical health professionals building relationships to enhance the recovery of patients.
- (2) How a robust LTC case supervision structure can support therapist learning and development in IAPT services.
- (3) How LTC-specific continued professional development can support all therapists.
- (4) How adapting CBT interventions for patients with a diagnosis of cancer and other long-term physical health conditions can enhance the recovery of patients.

Further reading

- Department of Health** (2005). *Supporting people with long term conditions*. Department of Health Gateway Reference 4230.
- Department of Health** (2008a). *IAPT: Long-term conditions positive practice guide*. Available at: www.iapt.nhs.uk/wp-content/uploads/2008/11/long-term-conditions-positive-practice1.pdf
- Department of Health** (2008b). *IAPT: Medically unexplained symptoms positive practice guide*. Available at: www.iapt.nhs.uk/wp-content/uploads/2008/11/medically-unexplainedsymptoms-positive-practice-guidetext.pdf
- IAPT** (2011). *IAPT Programme Review*. Department of Health. <https://www.uea.ac.uk/documents/246046/11919343/IAPT+Review+%282011%29.pdf/133a9732-badd-40ef-9aeb-87040b286744>
- IAPT** (2014a). *Medically Unexplained Symptoms/functional Symptoms Positive Practice Guidelines*. Department of Health. <https://www.uea.ac.uk/documents/246046/11919343/medically-unexplained-symptoms-positive-practice-guide-.pdf/55aea215-100e-4925-a968-65d6e89ad9b3>
- IAPT** (2014b). *Measuring Recovery and Improvement in Adult Services*. Department of Health. <https://webarchive.nationalarchives.gov.uk/20160302155408/http://www.iapt.nhs.uk/silo/files/measuring-recovery-2014.pdf>
- Mental Health Taskforce** (2016). *The Five Year Forward View for Mental Health*. Redditch: NHS England. Available at: <https://www.england.nhs.uk/wpcontent/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>
- National Collaborating Centre for Mental Health** (2018). *The Improving Access Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms – Full Implementation Guidance*. London: NCCMH; 2018. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/nccmh-iapt-ltc-full-implementation-guidance.pdf?sfvrsn=de824ea4_4
- National Collaborating Centre for Mental Health**. *The Improving Access to Psychological Therapies Manual*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2019/02/improving-access-to-psychological-therapies-manual.pdf>
- NHS England** (2017). *Five Year Forward View for Mental Health: One Year On*. Redditch: NHS England. Available at: <https://www.england.nhs.uk/wp-content/uploads/2017/03/fyfv-mh-one-year-on.pdf>
- NICE** (n.d.). *NICE Improving Access to Psychological Therapies*. Available at: <https://www.nice.org.uk/about/what-we-do/our-programmes/nice-advice/iapt>

References

- National Collaborating Centre for Mental Health** (2018a). *The Improving Access Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms – Full Implementation Guidance*. London: NCCMH; 2018. Available from: https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/nccmh-iapt-ltc-full-implementation-guidance.pdf?sfvrsn=de824ea4_4
- National Collaborating Centre for Mental Health** (2018b). *The Improving Access Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms*. London: NCCMH; 2018. Available from: <https://www.england.nhs.uk/wp-content/uploads/2018/03/improving-access-to-psychological-therapies-long-term-conditions-pathway.pdf>
- NHS England** (2016). *Implementing the Five Year Forward View for Mental Health*. Redditch: NHS England. Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf>

Cite this article: Panchal R, Rich B, Rowland C, Ryan T, and Watts S. The successful impact of adapting CBT in IAPT for people with complex long-term physical health conditions. *The Cognitive Behaviour Therapist*. <https://doi.org/10.1017/S1754470X20000306>