

Delivering Cognitive Behavioural Therapy to Advanced Cancer Patients: A qualitative exploration into therapists' experiences within a UK psychological service.

**Short title:**

Therapists' experiences of working with advanced cancer patients.

**ABSTRACT**

**Background:** Cognitive Behavioural Therapy (CBT) is commonly used to treat cancer patients with psychological disorders such as depression. There has been little qualitative research exploring the experience of therapists delivering CBT to patients with advanced cancer and long-term health conditions generally. Therapists views may help identify difficulties in delivering therapy and how these may be overcome. The aims of this study were to inform practice by qualitatively exploring the experiences of therapists delivering CBT to patients with advanced cancer.

**Design:** Sixteen semi-structured interviews were conducted with therapists from Increasing Access to Psychological Therapy (IAPT) services in London, UK, who had delivered CBT to patients enrolled on the CanTalk trial. Interviews were recorded, transcribed and analysed using Framework Analysis.

**Results:** Therapists reported positive experiences when working with the target population. Flexibility, adaptability and a consideration of individual needs were identified as important when delivering CBT, but the rigidity of IAPT policies and demand for services were perceived as problematic. Although therapists reported adequate training, specialist supervision was desired when delivering therapy to this complex population.

**Conclusion:** IAPT therapists can deliver CBT to advanced cancer patients, given therapists positive experiences evident in the present study. However, it was concluded that additional service and modifications of therapy may be needed before positive outcomes for both therapists and patients can be achieved.

**KEYWORDS:**

Cognitive Behavioural Therapy, Therapist, Cancer, Depression, Palliative care, Qualitative.

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**Key Practitioner Messages:**

- Patients with long term health conditions are confronted with many issues which can affect the uptake and delivery of CBT sessions.
- Psychological needs should be individually assessed and therapy adapted to suit these needs.
- Flexibility in appointment scheduling and discharge policies should be considered.
- Specialist supervisory support and training are recommended to deliver therapy to patients.
- Being able to liaise with clinical staff involved in a patient's care could also be considered in the psychological treatment of patients with long term health conditions.

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**INTRODUCTION**

Cancer is a debilitating illness resulting in approximately over 7 million deaths globally (Rosenstein, 2011). Depression is one of the most common psychological problems faced by cancer patients, with a prevalence rate of 5-20% (McDaniel, Musselman, Porter, Reed, & Nemeroff, 1995; Rosenstein, 2011). Depression in cancer contributes toward poor treatment adherence, hospitalisation and economic burden (Bowers & Boyle, 2003). Higher mortality rates are evident amongst advanced cancer patients with depression (Satin, Linden & Philips, 2009). Therefore, addressing depression in this population is important. Cognitive Behavioural Therapy (CBT) is a National Institute for Health and Care Excellence (NICE) approved treatment for depression (NHS London Strategic Clinical Networks, 2015).

The Increasing Access to Psychological Therapies (IAPT) service is a psychological facility available on the National Health Service (NHS) for people in England (Clarke, 2011). CBT is commonly accessed within IAPT services. IAPT services offer a 'stepped model' service with three levels, which can be used flexibly. In some situations, patients are offered the least intensive therapy initially (usually self-guided help) and only receive CBT after other therapies prove ineffective. However, in some cases CBT may be deemed the most appropriate therapy and therefore may be offered straight away. In 2014/15 CBT treatment in IAPT totalled 1,209,341 patients (Health and Social Care Information Centre, 2015). IAPT extended the service in 2011 to patients with cancer and depression as well as other long term health conditions as part of their four-year plan (Department of Health, 2011). In 2015, a service report indicated that 0.5-2% of cancer patients accessed psychological support within IAPT (NHS London Strategic Clinical Networks, 2015). Due to new and improved treatment and care, patients with advanced cancer have improved survival (Macmillan Cancer Support, 2017). Data from England's national cancer registry shows that 17000 people diagnosed with an advanced stage cancer lived two years or longer (Macmillan Cancer Support, 2017) and as a result it is possible that there may be an increased demand to deliver therapy to this patient group. By exploring the experience of therapists delivering CBT within IAPT, we may gain an understanding of how therapy can be improved, how therapists could be best supported

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within services and how services may be modified to suit this population. This information could be both clinically and logistically useful for future patients and IAPT services.

Research findings have suggested that improvements in psychotherapy outcomes are dependent on both patient and therapist factors (Baldwin, Wampold & Imel, 2007). For example, Owen and Hilsenroth (2014) reported that flexibility in therapy adherence was an important contributor to positive patient outcomes. It was also suggested that it was important to be able to adapt oneself as a therapist to suit individual patients (Lambert & Barley, 2001). Further research reported that patient motivation was associated with positive therapeutic outcomes (Luborsky, Auerbach, Chandler & Cohen, 1971). Huppert et al. (2001) reported that a therapist's prior experience was associated with therapeutic effect, with more experienced therapists achieving better patient outcomes than less experienced therapists. Thus, the role of the therapist appears to be as important as that of the patient in contributing towards successful outcomes. Despite this, there is a dearth of research in CBT exploring therapists experiences of delivering therapy using qualitative methodology. Qualitative research in this area is mainly focused on client perspectives of CBT (Hodgetts & Wright, 2007). However, exploring therapists experiences qualitatively may provide a deeper insight into the experience of therapy by allowing a more thorough exploration of experiences without use of restrictive categorical responses.

McGowan, Lavender and Garety (2005) explored therapists perspectives of delivering CBT to patients with psychosis and found where patients reportedly benefitted from therapy there was therapist-patient agreement in tasks and goal setting, a clear understanding and memory of sessions displayed by patients, and continuity of therapy. This finding provides an insight into therapists' experience of delivering therapy. However, this may not be generalisable to patients with other psychological issues as they are specific to psychotic conditions.

A small number of qualitative studies have explored therapists experience of delivering CBT through IAPT. In a study of people with learning difficulties, there was a lack of flexibility concerning discharge policies and the length and quantity of appointments (Marwood, Chin, Gannon & Scior, 2017). Therapists suggested that training and supervision were necessary to work with this population effectively and that prior experience and knowledge aided the

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therapeutic process. Similarly, Shankland and Dagnan (2015) reported that therapists felt that adequate training should be provided to work with this patient group. Therapists also expressed that therapy should be adapted to suit the client's needs rather than following a rigid approach. Though this research provides an overview of the use of CBT within IAPT services, this study was limited to people with learning difficulties. Therefore, there is a need to qualitatively explore the perspectives of therapists delivering CBT to other patients with chronic conditions including cancer.

We interviewed a selection of therapists who delivered CBT therapy within IAPT services to advanced cancer patients to address these research gaps. This was part of the 'CanTalk' trial: a randomised trial of the addition of CBT to usual care for people with advanced cancer and depression (Serfaty et al., 2016). The main findings of this trial will be reported elsewhere. In order to determine whether the costs outweigh the benefits of this particular treatment in this population, it is important to take on a holistic approach. Treatment effectiveness will be addressed in the main CanTalk trial paper, however qualitative research with therapists may provide a deeper insight into the benefits and limitations of delivering therapy within IAPT services. We primarily aimed to explore therapists' experiences of working with this population. Specifically, we sought to understand expectations of working with advanced cancer patients, issues arising in therapy sessions, training and supervision requirements and how to best support patients psychologically.

**METHODS*****Participants & Recruitment***

Participants were recruited using purposive sampling. Participants ( $n=16$ ) were therapists who delivered at least one session of CBT to advanced cancer patients as part of the CanTalk trial. As the CanTalk trial predominantly recruited participants from London, all participants in this study were therapists from IAPT services within London. All therapists who agreed to deliver therapy for the CanTalk trial were approached about the study by email; those who did not respond to the initial invitation were subsequently contacted by email and by telephone, one week, and two weeks later respectively. Therapists who delivered the full

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course of therapy to CanTalk trial participants and therapists who delivered therapy to CanTalk trial participants who dropped out before completing the full course of therapy were eligible to take part in the study. By including therapists who had delivered a varying number of sessions to trial participants we aimed to obtain a range of perspectives and experiences. Therapists who had attended a CanTalk trial training session but had not delivered therapy to any trial participants were excluded from taking part in the study. Ethical approval was granted by the London –Camberwell St Giles NRES committee, Central London REC3 ref 11/LO/0376. This study formed part of the National Cancer Research Network (NCRN) clinical trials portfolio registration number 10255, ISTCRN number 07622709.

***CanTalk Trial Training Session***

As part of the main trial, therapists were offered a bespoke 1-day CBT training package tailored to working with advanced cancer patients. Therapists were taken through a treatment manual, but it was advised that although they should use this flexibly and they should record the interventions they delivered. It was recommended that therapists seek routine supervision through their supervisor, but that they could always contact the trial team for more information.

***Procedure***

Interviews took place between August 2015 and March 2016 either at the therapists workplace or at University College London and lasted between 19 and 53 minutes. Interviewers (S.H and K.B) were researchers from the CanTalk trial and were involved in the collection of data from participants. No prior relationships existed between interviewers and therapists. Informed consent was obtained before the start of each interview. Semi-structured interviews were conducted using a topic guide for the purposes of consistency. The topic guide was developed by S.H, K.B and M.S. Given the dearth of research in this area, this work was exploratory. Researchers developed a mind map to generate areas of interest with possible questions and prompts. Questions were developed on the basis of Patton's (1987) six topics that could be asked in interviews. This includes: experience/behaviour, opinion/ belief, feeling, knowledge, sensory and background/ demographics. Discussions were held to

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determine the inclusion of questions and the format of the topic guide. Following agreement of questions, these were piloted with the first two therapists recruited and modified where appropriate. We began each interview with easy open questions to encourage rapport and the core part of the interview consisted of more in-depth questioning using open, non-leading questions to avoid influencing the participant. The topic guide (presented in Table 1) covered the therapist's knowledge of the patient's cancer diagnosis prior to their first appointment, their expectations of working with advanced cancer patients, training needs, overall experience of delivering CBT to advanced cancer patients and thoughts on how to best support advanced cancer patients psychologically.

[Insert Table 1 here.]

***Analysis***

Interviews were digitally recorded, transcribed verbatim and checked twice for accuracy. Data were analysed using Framework Analysis '...a matrix based analytic method which facilitates rigorous and transparent data management' (Ritchie & Lewis, 2003). Framework offers a systematic way of analysing qualitative data through matrices divided by individual case and theme. This approach was selected as it is considered suitable for research describing and interpreting events within particular contexts and where research may contain pre-defined samples with pre-defined questions delivered within a limited time period (Srivastava & Thomson, 2009). After familiarisation with the transcripts, K.B and S.H independently identified recurrent themes and a thematic framework was created. Data were then charted into themes. Disagreements about the thematic framework were resolved by discussion. Data were stored and managed in Microsoft Excel and each theme was displayed in a separate table, where columns represented subthemes and each row represented a participant. The thematic framework was an iterative process and was continually revised until K.B and S.H were satisfied that the framework reflected the data.

**RESULTS**

Overall, 55 therapists had delivered therapy and were invited to take part in the study. Thirty therapists were uncontactable because they had left the service, were on long-term leave or

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despite several attempts we were unable to establish contact with them. Nine therapists were not interested in taking part in the study.

Demographic details of the participants are summarised in Table 2. Participants were predominantly female ( $n=15$ ) and had between 1 and 18 self-reported years of experience of delivering therapy. Nine participants reported prior experience of working with cancer patients prior to the CanTalk study. All participants reported previous experience working with patients with other long-term health related conditions. Therapists delivered between 1 and 14 CBT sessions to patients.

[Insert Table 2 here.]

Five main themes emerged in the data: 1) Training, 2) Expectations, 3) Supervision and support, 4) Experience working with patients and 5) Suggestions for improvement. A total of fifteen subthemes were identified under the main themes (Figure 1).

**Training*****Adequacy of training***

Specialist training tailored to working with advanced cancer patients was provided to therapists as part of the CanTalk study. A number of positive comments were made regarding the adequacy of training. Therapists described the training as “*very good*” (T06), “*very comprehensive*” (T01) and “*useful*” (T03). Therapists reported that their way of thinking changed and that they began to think more deeply about the issues faced by cancer patients and how this may impact therapy. They also reported that they thought more about how CBT techniques commonly applied to physically healthy populations might be modified to suit the health care needs of cancer populations:

*... Some quite new skills in terms of...adjustment, just made me think quite carefully about adjusting what my expectations were about what the patient could do, and maybe not setting those too high. That was particularly useful I think. (T14).*



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*... I thought it was really good in the sense that it really got me to kind of think about things like, you know, the fatigue element, the pain element of cancer as well and how, some of the CBT interventions like behavioural activation, you could kind of tweak them slightly... (T15).*

Some therapists suggested that covering the topic of near death awareness within the training session was "*helpful*" (T04 & T11) and a discussion of "*existential issues*" (T01) beneficial in terms understanding more about the complex challenges faced by cancer patients.

***Additional knowledge and training needs***

In terms of further training needs, the feedback was mixed with therapists reporting different requirements. One therapist reported that it was important to address the emotional impact of cancer on therapists as it was "*very emotively*" challenging as well as "*evocative*" (T01). Another reported that "*peer training or supervision*" as well as "*top-up*" training (T05) would have been useful in helping being prepared for delivering therapy to this group. One therapist also reported that training on not only depression but "*other presentations... Or co-morbidity*" would have been beneficial (T07).

One common requirement was for further medical information. Seven therapists reported that this information would be useful during therapy sessions. Some reported that this would have helped in terms of being more prepared for "*what I am expecting really*" (T02) or would have helped them feel "*less anxious*" (T06). It was suggested that this information could be in the form of "*a letter from the hospital or something*" (T02), "*a one- off training day that was provided like once a year to all the therapists*" (T03) or having "*a nurse, or, someone's who's familiar with, for instance, the cancer treatments and their effects*" (T11) to deliver some medical information.

**Expectations*****Concerns about therapy and patients***

A number of therapists reported that they felt "*anxious*" (T06), "*apprehensive*" (T13) and "*daunted*" (T12) prior to delivering therapy to this particular patient group. Even though therapists reported feeling that they could see how CBT could be adapted for this population,

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they commonly worried that they would be "*trivialising their problems*" (T03) and "*rather than helping them...putting more pressure on them*" (T07). Therapists also frequently questioned "*how useful the therapy would be*" (T13).

Therapists also expressed concerns regarding their prior expectations of patients. Therapists expected patients who were "*very unwell*" (T12) and "*on the verge of dying*" (T08). Therapists also suggested that they presumed patients would be emotional displaying "*loads of tears*" (T09) and "*understandably distressed*" (T12).

***Expectations not met***

On the whole, a number of therapists reported that their prior expectations were not met when they delivered therapy to patients. Therapists reported feeling less anxious and more confident in the delivery and effectiveness of therapy once they began working with patients.

*...I'm a lot more confident...my assumptions about CBT and terminal cancer have been changed.*" (T05)

*...I'm not scared anymore. It's not as scary as I thought it was.*" (T08)

Therapists also expressed their prior expectations regarding patients' health had mostly not been met. It was reported that patients were "*still quite well*" (T07), "*better than what I expected*" (T08) and "*...none of that... outward sign that someone was receiving treatment for cancer*" (T12).

**Supervision and support*****Adequacy of support***

The adequacy of support and supervision provided varied. In some situations, therapists reported that they felt less comfortable discussing CanTalk cases in supervision as they were unsure about the expertise their supervisor had in this particular area.

*...I don't think people have got this experience to be honest with you...I did talk about her a lot in supervision but I don't think she understood, my supervisor.* (T08).

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*...There was a bit of kind of that 'oh we're expected to supervise you with these clients'...and they [in-house supervisors] didn't feel particularly confident about it... (T13).*

Therapists also felt that the CanTalk trial team were less forthcoming in providing therapists with additional support.

*...You didn't get any sort of specialist supervision...even if there were sort of tiny questions...it would have been nice to have that another contact...with the CanTalk team and there just wasn't... (T09).*

***Additional support required***

Eight therapists reported feeling well supported whereas six felt they would have benefitted from additional support. Almost all therapists expressed a need for expert supervision with those who have formal training in this field. All therapists acknowledged the value of being supported by someone with specifically expertise in cancer. Some therapists reported the need for more support from the study team therapists; some reported the need for external therapists with expertise and others required support from peers delivering therapy to the same population. Therapists reported that this additional support would have benefitted the patient:

*... I think my clients would have benefitted much more, if I'd been supervised with someone with experience of the protocol... (T07).*

*... I think that's really important... there's something about getting that actual specialist...supervision, that, you know, by somebody who knows about the treatments and that side of things...has worked with cancer patients before and they kind of know some of the issues that they go through. (T15).*

***Experience of working with patients******Patient related issues***

Patient wellbeing was commonly reported as a challenge and concern. In some circumstances, patients were too unwell to attend appointments. In other cases, the

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consequences of having cancer, such as cognitive damage or fatigue, made it difficult for patients to comprehend therapeutic principles. Side-effects caused by medication could create difficulty related to concentration and focus in sessions:

*... She can't come to sessions and stuff like that she feels too weak...It's quite difficult in terms of practicalities of actually attending therapy. (T08).*

*... Symptoms of the medication that they were taking might have kind of had an impact on, attendance and soon as well and also, I guess the ability to kind of focus in the sessions as well. (T15).*

*It's very difficult for my client to follow written information, his comprehension, his understanding of things, his retention is very, very difficult now... I summarise sessions for him and we talk about it but I'm not quite sure if he's retaining it so it's been challenging from many ends really. (T04).*

***Demand and flexibility issues within IAPT***

Another common concern and difficulty related to the rigidity in IAPT policies and demand on services. Therapists reported that IAPT policies can often result in patients being discharged if they do not attend a certain number of appointments. Therapists overlooked these policies given the health challenges faced by this population as well as the study trial requirements:

*I guess I was a bit more lenient when it comes to the discharge policy and DNA policy...Usually it would be three missed appointments and then they would be out of the service. Or if they don't attend an appointment and then don't respond to discharge letter within two weeks then they would be discharged as well... (T16).*

Another therapist found it difficult to coordinate her CanTalk appointment alongside her routine IAPT ones. This patient had mobility issues and was in a wheelchair. The therapist was therefore required to meet the patient at another area of the building and bring them to where the therapy was taking place. This consequently required more time than other clients: “... it was quite difficult just squeezing her into one [slot]” as “in IAPT you have to see

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*people back-to-back" (T03). One therapist felt that the CanTalk clients were receiving "a nicer experience" as patients were required to be seen within two weeks of being recruited to the trial, whereas in normal circumstances there is a waiting list for therapy "... my assessment slots are actually booked up...they're booked up three months in advance..." (T13).*

***External factors and the impact on therapy***

Some patient related external issues were reported to impact therapy sessions. External factors such as family, marital and medical appointment conflicts made it difficult for some therapists to deliver therapy in these situations:

*...there was lots of other things, family, relational things that were going on. One of the difficulties I have and had with that client is being able to stay protocol driven because there was other things going on in her life and it felt, for some reason it felt harder to move back than it does with my normal clients. (T05).*

Another therapist described how one patient had no trust or hopes in his or her GP as it took this GP a long time to diagnose the patient correctly. The therapist found this challenging to address the situation with the patient:

*...the first dilemma of all was she had no sense of trust or hope in her GP and she was blaming everything on her GP, for being misdiagnosed... she was furious and I found that difficult because, I felt as if I was placed between, you know, who do I support... (T01).*

***Level of patient commitment and the impact on therapy***

A commonly reported theme was the level of commitment to therapy. Therapists frequently made positive comments about patients. It was expressed that number of patients were enthusiastic, motivated, completed homework and attended sessions regularly:

*...very organised, one especially, very organised, very, consistent with the appointments... (T07).*

*Both my clients were actually very committed...They were very good. (T09)*

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One therapist's experience differed in that the patient "*had an extremely busy sort of work home, sort of domestic life and wasn't really prepared to give in any of those areas*" to fully commit to therapy sessions (T10). This eventually led to this particular patient withdrawing from therapy.

***Use of Therapy Materials***

Therapists were provided with a manual to guide therapy as part of their training. Another key factor that was perceived as important in the delivery of therapy was the way in which therapy materials were used. Some therapists were aware that therapy manuals could be used flexibly. Some therapists were unaware of this. However, it appeared that in almost all cases therapists found it difficult to adhere "*stay protocol driven*" (T05). Rather than following a rigid approach, therapists reported a need for "*space to talk about their health...*" (T05) and "*not just kind of follow a manual robotically*" (T06).

Some therapists emphasised that manual adherence would not be ethical and would go against the idea of patient-centred therapy which is something that these patients appeared to be seeking.

*... The idea of having like a sort of manualised treatment for this patient group... I'm not quite sure if I thought that at the training or subsequently, 'cos it didn't feel very patient centred. (T13)*

***Suitability of CBT for advanced cancer patients with depression***

In terms of the appropriateness of CBT for this population, nearly all therapists reported that CBT worked well for the patients they treated. Therapists were able to see the value of CBT for long-term health conditions even though some were previously unconvinced:

*I think it would be really useful actually. And having been part of the study actually has enabled me to think about CBT for longer term conditions including terminal cancer which I was more sceptical about before... (T05).*

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*I think it's fantastic. I think it's I think it's helped. It certainly has helped both my clients you know, especially the one with the kids. To be able to think about dying in a different way. (T09).*

**Suggestions for improvements*****Tailoring to individual needs***

A common occurring theme related to the idea of tailoring therapy to suit the requirements of the patient. Therapists reported that it was important to assess the patient requirements first, then alter the therapy and selection of the type of therapy to address this need.

*... You do need to think about it, the service users coming to you, how they present, is, it's, they're unique, you then devise a formulation based on their presenting problems... (T01).*

*... As with, with everybody I think you, you know, you do, you do enough assessments of people, some people are more suitable for a counselling approach, some people are more suitable for a CBT approach... (T11).*

***Flexibility requirements***

Therapists felt if IAPT are to successfully deliver therapy to this population, flexibility is essential. They argued that IAPT needs to “*seriously consider their thoughts around discharge and flexibility*” (T08). It was suggested that IAPT needed to adapt and contemplate “*later appointments if the medications make them too drowsy... different multimedia... skype sessions*” (T08). Given the healthcare concerns as described in ‘*patient related issues*’, therapists reported that IAPT need to consider “*the practical difficulties of each individual client... not to treat them like all the other client[s]*” (T11).

***The need for specialised services***

A number of therapists expressed they would prefer if this population were treated within specialist services rather than IAPT settings:

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*... I would rather than, the patient being seen in IAPT, especially busy IAPT, I would see it as more, rather than IAPT, a specialised service, where they do employ CBT therapist but is not as an IAPT it's more a specialised, you know, could be maybe in, in the hospital... (T07).*

Two therapists suggested having a service designed for this population which included other health care professionals, who could provide additional information about the patient. The therapists thought having this information would be beneficial:

*... The multidisciplinary working where you have somebody there who can tell you, we've got a physiotherapist on the team who knows all about the body stuff so she can just tell you all that... it's just invaluable... I think that chronic health conditions are better off treated in multidisciplinary teams. (T11)*

**DISCUSSION**

The present study sought to gain a perspective on the experience of therapists who delivered Cognitive Behavioural Therapy (CBT) to advanced cancer patients as part of the CanTalk trial. Specifically, we aimed to gain a deeper understanding of therapists expectations of working with advanced cancer patients, issues arising in therapy sessions, training and supervision requirements, and how to best support patients psychologically.

Overall, participants were positive about the training provided prior to working with patients but made some suggestions for improvement, such as the provision of additional medical information. A number of prior expectations emerged regarding concerns about therapy effectiveness and patient wellbeing, however on the whole these were not met. While there were some patient related issues related to attendance, physical wellbeing and external factors such as family conflict, therapists overall experience of working with this patient group was positive. In fact, many therapists felt that there was value in CBT for this population. The adequacy of supervision varied, with a number of participants commenting that they and their patients would have benefitted from 'expert' supervision. A number of factors were identified as important when delivering therapy including adaptability in therapy and flexibility in appointment scheduling. Participants made suggestions regarding how to best treat advanced



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cancer patients with psychological issues with some highlighting the need for specialist services and being able to liaise with medical professionals.

Training enabled therapists to reflect on how CBT could be adapted for patients with advanced cancer. Therapists suggested a better understanding of the challenges faced by this population, such as near death awareness. Similarly, therapists in other qualitative research suggested that specialist training, such as the training therapists received for the CanTalk trial, is important for therapists delivering therapy to individuals with learning disabilities (Marwood et al., 2017; Shankland and Dagnan, 2015). Therapist competence has additionally been found to be associated with improved therapy outcomes, with more competent therapists having better patient outcomes (Kuyken & Tsivrikos, 2009). This highlights the importance of adequate training purposefully adapted to suit the population at hand.

A number of participants expressed anxiety about working with cancer patients but this did not persist once they had starting working. This is not surprising as there is negative stigma attached to palliative care, with advanced cancer patients and their caregivers in one study describing palliative care as being associated with death which provoked fear and avoidance (Zimmermann et al., 2016). Individuals may have negative perceptions about what working with palliative care patients may be like and the challenges that this may entail. Clinicians early in their careers who are more anxious are less likely to deliver the full evidence based form of CBT and are more likely to focus on less challenging aspects of therapy (Levita, Salas Duhne, Girling, & Waller, 2016). We recommend addressing clinicians' anxiety during training. We identified further training needs, in particular therapists desired more medical information to help allay therapists' anxiety. Addressing such concerns at an early stage may prevent possible adverse consequences on therapy sessions and patient outcomes.

Participants views regarding the adequacy of supervision provided varied, with some reporting better support than others. Several therapists felt that they, and their patients, may have benefitted from 'expert' supervision. Specifically, supervision with someone with experience in delivering therapy to advanced cancer patients. This finding is supported by Marwood et al. (2017) who explored the experience of therapists delivering CBT to people with learning disabilities in which therapists expressed a need for specialist supervision when

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delivering therapy. Additionally, Naylor et al. (2012) suggested that IAPT workers working with physically ill patients require on-going supervision with professionals, such as clinical health psychologists, with experience of working with the same patient group.

Therapists frequently commented that patients were motivated and committed to therapy sessions by completing homework tasks and attending therapy sessions. This highlights the importance of patient commitment to therapy, as patient motivation and continuity of therapy sessions appears to assist the therapeutic process (Luborsky et al., 1971; McGowan et al., 2005). Therapists reported that if IAPT were to successfully deliver therapy to this population, flexibility is essential. Previous research has identified the rigidity of the service as a reason for patient non-attendance at IAPT with participants reporting a lack of choices regarding appointment time and difficulties fitting appointments into their lives (Marshall et al., 2016). Similar findings have been observed in people with learning difficulties where a lack of flexibility in appointment scheduling and discharge policies within IAPT services were observed to be too constraining (Marwood et al., 2017). Cancer patients are likely to have a number of medical appointments, which, in addition to the side effects of some cancer treatments, may make attending weekly IAPT appointments challenging. This may be more pronounced for patients who continue to work. Therapists also suggested attendance was impaired when patient's symptoms and medications caused physical problems and cognitive difficulties and where mobility issues were present, requiring more time. For IAPT to successfully deliver therapy to other patients with cancer and/or chronic conditions, additional allowances around the length and scheduling of appointments and leniency of discharge policy are required.

Participants also suggested that therapy should consider individual needs such as different physical problems, presentations of depression and everyday challenges faced by patients and be adapted on this basis. Wroe, Rennie, Gibbons, Hassy, and Chapman (2015) sought to understand the effectiveness of IAPT interventions for patients for Type 2 Diabetes and concluded that for standard IAPT interventions to be effective, adaptations should tailor the intervention to the condition in question. Similarly, Shankland and Dagnan (2015) reported that adaptability was vital in the delivery of therapy to those with learning difficulties within

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IAPT to achieve positive patient outcomes. Adaptability and a consideration of individual needs are commonly reported as important in the delivery of therapy irrespective of patient conditions (Owen & Hillsworth, 2014; Lambert & Barley, 2001).

Consistent with recommendations by Wroe et al. (2015), some therapists suggested a range of healthcare professionals should be available for consultation to help understand the patient's physical state so best support them. Therapists were keen to receive basic medical information about patients. If IAPT services are going to be increasingly required to treat patients with long term health conditions, it may be important to determine a pathway for therapists to access this information. Some therapists also believed that multidisciplinary expertise was required and specialist facilities were a more appropriate setting to treat cancer patients. Our findings suggest that there is a need to consider the most appropriate setting to treat patients as well as determine pathways to enable multidisciplinary and collaborative working.

**Clinical recommendations**

The current guidance is to extend IAPT services to cancer patients and the following recommendations drawn from our findings may aid service delivery in IAPT settings (Department of Health, 2011; NHS London Strategic Clinical Networks, 2011). Although participants commonly reported positive experiences working with patients, services may be enhanced when delivering therapy to this population by:

- I) delivering specialised training and supervision by providing cancer specific information and addressing therapists prior anxieties and ensuring supervisors with expertise in the field of advanced cancer are available;
- II) ensuring the length and scheduling of appointments and discharge policies are flexible to suit patient wellbeing;
- III) assessing patient commitment to therapy, including willingness to carry out CBT homework tasks, to minimise attrition and;

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IV) emphasising that therapists do not need to adhere rigidly to treatment protocols, but rather consider individual patient needs.

**Further research**

Previous qualitative research has focussed on patients views of therapy, and there is limited research exploring therapists views (Hodgetts and Wright, 2007; Baldwin, Wampold & Imel, 2007). To our knowledge, this is the first study exploring CBT therapists' views of delivering therapy to people with advanced cancer. IAPT is being expanded to include treatment of people with long term conditions. Further qualitative research will be helpful in informing practice to explore whether therapists feel that CBT delivered through IAPT is appropriate for people with other long-term conditions.

**LIMITATIONS**

All participants were therapists from London IAPT services and they may not be representative of therapists in other services in England. Although it may be beneficial to interview therapists from other areas in England, therapists surveyed came from centres from services delivering therapy to a diverse demographic population.

All but one therapist were female. However, as the majority of therapists who delivered therapy as part of the CanTalk study were female ( $n=13$  vs.  $n=32$ ), this reflects the ratio of male to female psychologists in the UK where nearly 70% of psychologists are female (Office for National Statistics, 2016).

**CONCLUSIONS**

Therapist views about how best to treat a physically ill population is rarely undertaken, but may prove insightful, especially as qualitative research usually focusses on patient views. Therapists suggest that there is scope for depressed advanced cancer patients to be treated within IAPT services with CBT, but that modifications in its delivery are necessary to ensure a positive experience for both therapists and patients. Further research to generate a robust evidence base to inform ways of delivering treatment to people with other chronic health conditions is required.

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