

Understanding the Factors That Contribute to  
the Outcome of Cognitive Behavioural Therapy  
as Adjunct to Medical Treatment in a Sample of  
Individuals with Psoriasis:  
A Constructivist Grounded Theory Study

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### **Declaration**

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### **Abstract**

Psoriasis is a chronic autoimmune skin condition that can impair psychological, social, and physical functioning. The psychological implications of psoriasis can be highly disturbing and a significant number of patients with psoriasis live with considerable and enduring psychological distress. An accumulating body of evidence suggests that Cognitive Behavioural Therapy (CBT) may be the most effective in ameliorating the psychological distress resulting from living with psoriasis. CBT has been effective in reducing the emotional distress, the quality of life impairment associated with psoriasis and as a result the clinical severity of it. The mechanisms behind these changes are not known, however. Outcome studies in CBT have shown that common factors (i.e., therapeutic relationship) and/or technical ones (i.e., CBT techniques) account for therapeutic change. The aim of this study is to identify the factors that influence the treatment process and the outcome of CBT for individuals with psoriasis and develop a model of it.

This study adopted a constructivist Grounded Theory approach. In-depth semi-structured interviews were conducted with nine patients who had completed a course of CBT within the Psychodermatology Clinic of a hospital in England. From the analysis emerged the model of “Guided Therapeutic Growth” which was the core conceptual framework that subsumed the factors that influence the patients’ experiences of their therapeutic processes in CBT. These factors were: (a) “feeling engaged with the therapeutic process”; (b) “establishing a trusting therapeutic relationship”; (c) “legitimising the expression of distress associated with psoriasis”; and (d) “guided cognitive restructuring of the meanings attached to psoriasis”.

The integration of these four interrelated factors forms a tentative model that was found to impact the therapeutic growth by reducing distress, alleviating emotional pain and helping individuals with psoriasis to become more self-compassionate, all of which were found to motivate and empower them to move forward and achieve positive changes in their adjustment to their psoriasis. Conversely, the absence of these factors or the presence of certain hindering conditions could compromise the therapeutic experience of CBT and jeopardise progress. In this context, the following hindering conditions were reported: (a) negative preconceived notions about homework; (b) too much or too little directiveness by the therapist; and (c) externalisation process of emotional release experienced by the patient as too revealing.

*Keywords:* CBT, psychodermatology, psoriasis, therapeutic factors, constructivist grounded theory

## Introduction

### Overview

This thesis explores the factors that contribute to the outcome of CBT for individuals with psoriasis<sup>1</sup>. Psoriasis can be a debilitating skin condition, affecting 3% of the population in the United Kingdom (UK) and Ireland (NICE, 2012). The first section outlines the causes and symptoms of psoriasis. The following section describes the psychological factors present in psoriasis; the psychological implications of psoriasis can be highly distressing and a significant number of patients who have developed the condition present with considerable and enduring psychological distress (Fortune, Richards, & Griffiths, 2005). In order to reduce psychological distress, a variety of psychological interventions that have been employed are critically appraised and examined in the following section. Based on research findings, the review concludes that CBT can be highly effective for managing the psychological symptoms of psoriasis. The review then considers past and current literature on the effectiveness of CBT. This discussion provides an important foundation for exploring the reasons accounting for therapeutic change and introduces the central question of this investigation around the factors that may be implicated in positive and less positive outcomes in CBT for psoriasis. The final stage of the review concentrates on the rationale and aims of the present study. A reflective section, based on the researcher's expectations, beliefs and personal experiences, illustrates the stimulus for the development of this research. Throughout this chapter, links to Counselling Psychology are considered.

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<sup>1</sup> Please note that the term patient and client will be used interchangeably.

## **Understanding Psoriasis**

### **Clinical features of psoriasis.**

Psoriasis is a chronic autoimmune skin condition characterised by red, inflamed, and flaky areas of the skin (Fry, 2004). In the UK, the prevalence of psoriasis has been reported to be between 0.24% and 1.5% (Conway & Currie, 2008). Earlier studies found that about 125,000 people in the UK suffer from psoriasis and every year about 20,000 people develop it (Finlay, 2000). Symptoms include itching, bleeding and cracking of the skin, which can lead to dry skin and raw open wounds (Globe, Bayliss, & Harrison, 2009). Pruritus (itching) and scaling are the most commonly reported (75–80%) clinical symptoms of psoriasis (Fortune, Richards, Main, & Griffiths, 1998) causing significant disruption to the individual's quality of life (Globe et al., 2009).

With psoriasis, the body produces skin cells every three to seven days, whereas a more usual production rate is three to four weeks. This overproduction results in a build-up of skin cells, which form patches (Halprin, 1972). These red skin patches usually appear on the sufferer's elbows, knees, scalp, and lower back. However, in severe cases, the patches can appear anywhere on the body, causing itchiness and considerable discomfort. Although psoriasis has an unpredictable course and can start at any age – from the first to the final years of life – the usual age of the onset in adults is under 35 years old (NHS, 2013).

### **Aetiology.**

Genetic studies have identified genetic factors (30%) in the aetiology of the condition (Duffy, Spelman, & Martin, 1993). However, studies that are more recent have shown that familial predisposition is less likely to cause the onset of psoriasis than was believed and that

environmental factors are more influential (Picardi et al., 2007). For example, specific stimuli, such as injuries, throat infections, or certain drugs, can exacerbate or lead to psoriasis (NHS, 2013). Psychological stress, in particular, has also been considered to be a triggering and exacerbating factor in psoriasis (Ingram, 1954; O'Leary, Creamer, Higgins, & Weinman, 2004; Picardi & Abeni, 2001) irrespective of hereditary predisposition (Fortune et al., 1998). The results of these studies therefore suggest that the exact mode of inheritance is not known yet and that the aetiology of psoriasis is more likely to be a combination of factors (Picardi et al., 2005).

### **Medical management.**

Psoriasis is incurable but there is a wide variety of medical treatments that offer symptom relief and reduction in the frequency and duration of flare-ups (Laws & Young, 2010). These include topical treatments, such as emollients; Ultra-Violet light therapy; systemic tablets; and injected protein-based drugs targeting specific parts of the immune system that cause the inflammation of psoriasis rather than just the symptoms. Nevertheless, some of these treatments can be time-consuming, inconvenient, and, in the case of certain ointments, even smelly (Leary, Rapp, Herbst, Exum, & Feldman, 1998). Patients often report that irrespective of their effectiveness, these medical treatments fail to meet their needs because the psychological distress is high and ongoing (Fortune, Richards, Griffiths, & Main, 2004). One might wonder whether standard medical management approaches are able to capture the complexity of human experience and whether there is a need to adopt a perspective that could also look at the psychological aspects of health (Papadopoulos, 1997).

### **Psychodermatology: A Discipline That Brings the Mind and the Skin Together**

The skin is the largest human organ and acts as an interface between an individual's internal and external environment. Human emotions can generate visible physiological changes to the skin. For example, people blush when they feel embarrassed or produce goose bumps when they are excited (Silvan, 2004). This shows that the skin and the mind are intertwined functionally, forming a close relationship, and a discrepancy in one can affect the other (Jafferany, 2007).

Psychodermatology is the discipline that incorporates and studies this close relationship and looks at the individual holistically. According to Walker and Papadopoulos (2005, p. xi), psychodermatology is "as much an ethos as a discipline; a professional, clinical and research-orientated awareness and acceptance of the psychological and social implications of dermatological conditions".

Society's great emphasis on attractiveness and appearance creates a variety of challenges for individuals with dermatological conditions such as psoriasis, research in psychodermatology has looked into ways of considering the patient holistically and addressing issues pertaining to his/her quality of life (Walker, 2005). Similarly, the discipline of Counselling Psychology also acknowledges the importance of looking at a person holistically and developing a person's potential rather than focusing on curing disease and sickness, as the medical model does (Woolfe, 1996a). Therefore, the ethos of this discipline sits well within this framework. This is of the utmost importance because over the last decades many more Counselling Psychologists have come to practice within the NHS, wherein a significant number of individuals with psoriasis are being managed under a purely medical model that focuses on illness, medication,

and expert interventions (Hammersley, 2010). Hence, Counselling Psychologists have an important role in providing a humanistic response that is not reducible to formulaic prescriptions (Strawbridge & Woolfe, 2010) and in trying to become agents of individualised treatment in this highly medicalised environment.

### **The Cognitive Conceptualisation of Psoriasis**

In understanding the factors that are implicated in the development and exacerbation of a skin condition, a theoretical model needs to be provided. The Illness Representation model (Leventhal & Nerenz, 1980; Lau, Bernard, & Hartman, 1983) has been proposed as the most useful theoretical framework in this field to examine how patients conceptualise their illness. Illness beliefs have been found to be the most consistent predictor of psychological distress in individuals with psoriasis (Fortune, Richards, Griffiths, & Main, 2002; Scharloo et al., 2000). Research has shown that cognitive, emotional, and behavioural responses to illness can both influence and be influenced by a person's self-concept (i.e., a person's information processing network) and as a result can affect emotional well-being, quality of life (Weinman & Petrie, 1997), psychosocial adjustment to the illness, and interactions with others (Kleinman, 1988).

From a Counselling Psychology perspective, it is important to understand a *patient's conceptualisation and understanding* of his/her condition in order to better empathise with their experience and to work on challenging illness cognitions and behaviours that are negative/maladaptive and that predispose individuals to experience distress (Thompson & Kent, 2001). Indeed, literature has supported the effectiveness of cognitive interventions when used to challenge illness representations because targeting beliefs about illness facilitates the

development of adaptive coping responses, enhances immune functioning, and improves general well-being (Broome, 1989; Petrie & Weinman, 1997).

### **The Psychological Impact of Living with Psoriasis**

The psychosocial implications of skin diseases are highly disabling (Vladut & Kállay, 2010) and the level of disability is comparable to that of patients with cancer, arthritis, and heart disease (Lawrence-Smith, 2009). Psoriasis can be a stressor in itself, causing even more distress than fungal infections (Fava, Perini, Santonastaso, & Fornasa, 1980) and vitiligo (Porter, Beuf, Lerner, & Nordlund, 1987).

Attractive individuals are perceived as more worthy, successful, and competent (Walker & Papadopoulos, 2005). Consequently, people who do not fit stereotypes of having attractive skin because of their skin condition oftentimes feel unworthy, stigmatised, and rejected (Clarke, 1999; Fortune, Richards, & Griffiths, 2005). Even from biblical times, this discrimination was apparent; those with a skin condition have been rejected, socially stigmatised, and considered to be morally corrupted (Papadopoulos, Bor, Walker, Flaxman, & Legg, 2002; Wilson, 1966).

A person with a visible difference is expected to adjust to society's demands but also to bodily changes. When they cannot adjust successfully because there is a discrepancy between society's expectations and their skin condition, they often feel diminished and psychologically distressed (Kellet & Gilbert, 2001), and they can face emotional and social difficulties (Fox, Rumsey, & Morris, 2007; Papadopoulos, Bor, & Legg, 1999) manifested as social anxiety, depression, poor self-image, and low self-esteem (Walker & Papadopoulos, 2005). These experiences are found to

confirm existing negative core beliefs, developed mainly in childhood, and could lead to the development of maladaptive coping behaviours, such as avoidance, withdrawal, anticipatory behaviour, and concealment (Kent & Thompson, 2002), that exacerbate the condition (flare-ups) and hinder psychological adjustment.

In relation to the psychological implications, the impact of felt stigma—meaning the anticipation of rejection (Goffman, 1990)—has been found to be the worst feature of living with psoriasis because it leads to an increased use of maladaptive coping strategies and results in interpersonal concerns (Fortune, Main, O’Sullivan, & Griffiths, 1997; Hill & Kennedy, 2002; Weiss & et al., 2002; Uttjek, Nygren, Stenberg, & Dufaker, 2007). Ginsburg (1995) found that 20% of people with psoriasis had been asked to leave a restaurant, swimming pool, or other public place because of their appearance. The experience of stigmatisation has been found to be associated with the development of appearance anxiety and depression (Fortune et al., 2005).

Depressive symptomatology is also a clinically important feature of psoriasis (Akay, Pekcanlar, & Bozdag, 2002), with women being affected twice as often as men are (Koblenzer, 1990). It is associated with feelings of embarrassment, shame, helplessness, and suicidal ideation (Magin, Adams, Heading, Pond, & Smith, 2009; Wahl, Gjengedal, & Hanestad, 2002). In some studies, the severity of psoriasis is found to be directly correlated with the severity of depression (Devrimci-Ozguve, Kundakci, Kumbasar, & Boyvat, 2000; Gupta & Gupta, 2003; Gupta & Gupta, 1998; Leary et al., 1998). Studies that are more recent have not found any direct association and have suggested that the impact of psoriasis severity on depression is mediated by

other factors, such as a stronger belief in the consequences of having the disease (e.g., Fortune et al., 2004).

Anxiety has also been well documented in the literature; in the UK, 7,100 annual diagnoses of anxiety are attributable to psoriasis (Kurd, Troxel, Crits-Christoph, & Gelfan, 2010). This figure is found to be notably higher than that for individuals with depression (Russo, Ilchef, & Cooper, 2004). Research documents that patients with psoriasis score higher on anxiety scales than do control groups as a state and personality trait (Zeljko-Penavic, Situm, Babic, & Simic, 2013), oftentimes indicating a psychiatric anxiety disorder (Mizara, Papadopoulos, & McBride, 2012). They even experience more intense symptoms of physical anxiety and fear of negative evaluation than do patients with eczema or vitiligo (Stangier, Ehlers, & Gieler, 2003). In order to cope, individuals with psoriasis use maladaptive mechanisms, such as pathologic worrying—the cognitive component of anxiety (Fortune et al., 2005)—anticipation, and avoidance, which all maintain the anxiety (Zacharie et al., 2004).

This discussion so far suggests that psoriasis is a complex medical condition that instigates frequent and debilitating physical, psychological, and sociological effects. Moreover, the severity of psoriasis and its impact on individuals vary greatly and can be experienced differently. Indeed, literature reports that some individuals cope well with their condition, perceiving psoriasis as a minor irritation, whereas for others it can have a significant impact on their lives (Papadopoulos & Bor, 1999). Therefore, in order to understand how an individual copes with their condition, we need to look at their subjective experience. Counselling Psychology's primary concern with the

individuality and uniqueness is an important factor to consider here because within this discipline practitioners seek to understand the client's inner experience (Woolfe, 1996b).

Cognitive processes (i.e., anticipation of others' reactions, beliefs of being negatively evaluated) and behavioural strategies engaged in by patients seem to function as a risk factor for the emergence and maintenance of distress. It is not therefore surprising that interventions targeting these unhelpful beliefs and behaviours could be beneficial for this population. Indeed, the application of such interventions has been reported in the literature and their effectiveness is reviewed below.

### **Research Trends in Psychological Interventions for Psoriasis: Setting the Research Context**

In response to clinical and research observations, a variety of psychological treatments have been employed with individuals with psoriasis. These therapies have ranged from hypnosis (e.g., Hawkins, Vargha, & Szabo, 2009) and emotional disclosure (e.g., Vedhara et al., 2007) to group therapy (e.g., Bremer-Schulte, Cormane, Van Djik, & Wuite, 1985) and CBT (e.g., Fortune, Richards, Griffiths, et al., 2002; Fortune et al., 2004).

#### **Hypnosis.**

The literature provides some interesting case examples of the effectiveness of hypnosis as a psychological intervention for the treatment of psoriasis. Hawkins et al. (2009) utilised hypnosis with a 22-year-old client with psoriasis who reported a decrease in psychological and physical symptoms. Tausk and Whitmore (1999) used a control group to conduct an arousal reduction hypnosis intervention as an adjunct to standard medication. Their results showed differences in the physical outcomes between participants who were deemed highly or moderately hypnotisable

but failed to show any significant differences in physical outcomes between the intervention and the control groups. Similarly, in their study, Boncz, Farkas, and Hunyadi (1990) used hypnosis as an adjunct to PUVA and obtained positive results associated with reduced itchiness, improved sleep, and greater well-being. Waxman (1973) treated a female patient with psoriasis under hypnosis for two months and reported clear skin and low scores on neuroticism. Frankel and Misch (1973) also supported the effectiveness of hypnosis by describing the case of a man with a 20-year history of psoriasis and social withdrawal who achieved significant improvement in his skin and increased confidence. An older case study on psoriasis and hypnotherapy is that of Kline (1954), who treated a forty-year-old psoriatic woman for seven weeks. Results were positive, with 75% clearer skin, though without any psychological improvement.

Although the outcomes of these studies appear to be successful, certain limitations need to be taken into consideration regarding hypnosis's effectiveness. Firstly, the lack of information regarding pharmacological treatments, severity of the disease, level of psychological distress, demographics, and actual statistical analysis in some of the cases questions the strength of the evidence. Secondly, according to Fried and Hussain (2008), only 10% of people can reach deep trance levels and not everyone can be hypnotised. It might therefore be argued that hypnosis can be employed effectively only for individuals with psoriasis who can reach hypnotic levels easily and that transferability of the findings of such an approach to the broader population is not suitable. Thirdly, although the outcome was positive, no assumptions can be made regarding the reasons or factors that made it positive. Interviewing participants and understanding the world from their perspective in terms of what worked for them would have enhanced our understanding of the specifics and would have improved the treatment and care of these individuals. This

understanding would be best supported by a qualitative approach, such as Constructivist Grounded Theory (CGT), that captures valuable insights derived from participants' accounts and builds a theory that can inform practice (Birks & Mills, 2011).

### **Emotional disclosure (ED).**

Vedhara et al. (2007) used an ED arousal reduction intervention for patients with psoriasis. ED is an expressive intervention in which participants are invited to talk or write about stressful and/or traumatic events from the past for a short period of time (Meads & Nouwen, 2005). It is associated with improvements in emotional well-being, a reduction in the severity levels of the disease and beneficial changes in the immune system (Donnelly & Murray, 1991; Pennebaker, Barger, & Tiebout, 1989; Spiegel, 1999).

In their study, Vedhara et al. used validated outcome measurements, such as the Psoriasis Area and Severity Index (PASI)<sup>2</sup> (Fredriksson & Pettersson, 1978), the Hospital Anxiety Depression Scale (HADS)<sup>3</sup> (Zigmond & Snaith, 1983), and the Dermatology Life Quality Index (DLQI)<sup>4</sup> (Finlay & Khan, 1994). Participants, who were randomly allocated, had 20 minutes on each of four days to write about their thoughts and feelings in relation to an upsetting experience. Control participants were asked to write only about what they did the previous day (factual information). The results revealed a non-significant improvement in disease severity and in quality of life.

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<sup>2</sup> The PASI is the most widely used clinical tool for the measurement of psoriasis severity. The scores range between 0 (no psoriasis) and 72 (very severe psoriasis).

<sup>3</sup> A self-assessment scale that has been developed and found to be a reliable instrument for detecting states of depression and anxiety in the setting of a hospital medical outpatient clinic. A person can score between 0 and 21 for either anxiety or depression.

<sup>4</sup> The Dermatology Life Quality Index questionnaire is a ten-question questionnaire used to measure the impact of skin disease on the quality of life of an affected person and it is designed for use in adults. The scores range between 0 (no effect at all on patient's life) and 30 (extremely large effect).

Another study examining the effectiveness of ED in combination with phototherapy was conducted by Paradisi et al. (2010). They found that the beneficial effects on physical severity and quality of life (QoL) outcomes were attributable to the phototherapy; they did not find any difference in outcomes between the intervention and control groups. There was also a high attrition rate (49%), which was not explained. One limitation of the study was the lack of information about the analyses between the groups; it merely reported that participants had not reached statistical significance, without giving any further explanations.

#### **Mindfulness meditation.**

Kabat-Zinn et al. (1998) used a mindfulness meditation intervention in patients with psoriasis undergoing phototherapy. They randomly assigned 37 participants to a stress-reduction audiotape course or to the usual treatment (i.e., no tape). Results showed that the participants who received the former type of therapy reached skin clearance faster. However, there was no difference in the psychological outcomes between the groups.

#### **Music intervention therapy.**

In a study of medical resonance therapy with music intervention, Lazaroff and Shimshoni (2000) obtained greater improvements in skin condition for the intervention group (65%) than for the control group (20%), which was instructed to “somehow relax”. The intervention group showed a larger reduction in the intention to scratch (86%) than the control group did (29%). However, the statistical difference between the groups cannot be demonstrated because the statistics tests are not included. There is also a lack of baseline and outcome measurements and, as a result, the statements made in the paper cannot be supported rigorously.

### **Group therapy.**

In an unpublished PhD study, Fordham (2012) adopted a mixed-methods design to examine the effectiveness of a group mindfulness intervention for individuals with psoriasis. Results showed improvements on physical and QoL measurements but failed to show changes in stress and emotional distress. Semi-structured interviews shed further light, revealing that process factors were inhibiting learning of the intervention skills. These included (a) difficulty in finding the time and the energy to practice, (b) problematic group dynamics (e.g., participants not relating to each other due to differences in the severity of psoriasis), and (c) the particular teaching style, which relied on experiential learning were all barrier to the assimilation of therapeutic skills. Although this study experienced a high attrition rate, it significantly enhanced understanding of treatment outcome by including participants' qualitative data.

In order to assess the efficacy of group therapy, Seng and Nee (1997) recruited ten participants with psoriasis. The results indicated a positive therapeutic outcome because the majority of participants gained a better understanding of their condition, learned ways to cope with stress, and achieved feelings of acceptance. No objective measures on the severity of disease (e.g., PASI) or on psychological distress were used, no follow-up was employed, and no control group was used. Moreover, neither the method nor the analysis of the results is evident in the paper. Therefore, valid conclusions cannot be drawn on efficacy.

The oldest study on group treatment was conducted by Brenner-Schulte et al. in 1985. The results revealed a change in the experimental group compared to the control one but valid assessments on the changes between prior and post treatment cannot be made because the outcome measures were not reported in detail. Neither the analysis of the data nor the evidence

for and against the decrease in levels of depression and anxiety was reported, making the findings of this study crude. Moreover, the efficacy of the intervention *per se* cannot be supported because conventional therapies (i.e., PUVA) were also used during the intervention period.

### **Combined psychotherapy interventions.**

Zacharie, Oster, Bjerring, and Kragballe (1996) conducted an experimental study in order to investigate in a blind-controlled manner the effects of a combined psychological interventions programme (CBT, imagery, and relaxation) on patients with psoriasis. Results showed differences between the groups in physical and psychological outcomes but these were moderate. This study lacked statistical reporting, such as p values, and there was no follow-up after the end of treatment.

Price, Mottahedin, and Mayo (1991) examined the effectiveness of group therapy by using combined group psychotherapy interventions (relaxation, self-hypnosis, and support group discussions). The results revealed a significant reduction in anxiety levels and an increase in self-esteem ( $p < .05$ ) in comparison to the control group. However, there was no difference in physical outcomes between the participants and the control group.

A conclusion that can be drawn from these studies is that although the results revealed a positive outcome, they present with methodological flaws in their designs that make the evidence for the efficacy of these interventions poor. Moreover, because these studies comprised a package of interventions, it remains unclear which of the many components were sufficient for therapeutic change. Further exploration is needed to identify what participants find useful in their therapy

and what contributes or inhibits therapeutic progress. A qualitative approach that did not just explore meanings related to effective factors but also explained these actual phenomena would be of utmost importance. CGT is an approach that goes beyond exploring meanings and generates theories based on deep explanations of phenomena. It was therefore considered suitable for resolving such problems.

Another interesting observation is that these studies had a larger female than male sample. Women with psoriasis are found to be more stressed than men (Richards & Fortune, 2006) because their psychological symptoms are more severe and common (Sampogna, Tabolli, & Abeni, 2007). In light of this, one might wonder about the potentially high motivation levels in women to receive therapy. Indeed, numerous studies suggest that women access primary care services more frequently than men do and that women are found to seek medical help for cosmetic problems more often than men do (Kleck & Strenta, 1980; Nathanson, 1975). In addition, it has been reported that men are more likely to suppress distressing feelings because they consider them to be a sign of weakness, and that they are more hesitant to admit their concerns about their appearance than women are (MacGregor, 1990). Counselling Psychology's central value of paying particular attention to the meanings, beliefs, context, and processes constructed both within and between people (BPS, 2010a) is an important one to consider here because there may be different processes in the way genders might assess their skin condition and in what they need from therapy.

### **Cognitive behavioural therapy (CBT).**

According to the CBT framework, dysfunctional thoughts and beliefs are shaped in early (or later) life experiences and are maintained by distorted interpretations and behaviours. Once

activated, these beliefs trigger negative automatic thoughts that in turn trigger negative affect, physiological symptoms, and dysfunctional behaviour in a cyclical manner (Beck, 1976; Sanders & Wills, 2005). CBT places emphasis on the here-and-now and uses rational thinking and behavioural activation. Sessions have an agenda and a review of homework assignments. It also makes use of case conceptualisations, which facilitate understanding of how the current impasse has been a recurrent difficulty and helps people challenge and reframe this negative thinking in order to overcome emotional blocks (Moorey, 1996). It relies on collaborative empiricism where client and therapist work together to help the client overcome presenting difficulties (Padesky, 1996).

On the basis of the CBT framework, according to which the patient's psychological distress is maintained by cognitive factors and meanings (Johnsen & Friberg, 2015; Lawrence-Smith, 2009; White, 2001), and the Illness Representation model, Fortune, Richards, Griffiths, et al. (2002) conducted a study in order to investigate the effects of a cognitive behavioural psoriasis symptom management programme (PSMP) on patients' perceptions of their condition and their coping strategies. For the analysis of the results, the authors used independent t-test analyses of the mean difference between PSMP and standard care groups. The findings at the 6-month follow-up revealed that the control group who opted for the PSMP in addition to their standard psoriasis treatment showed significant reductions in the clinical severity of psoriasis, in psychological distress, and in psoriasis disability and stress outcomes. Supporting the psychoeducational element of CBT, the authors concluded that educating patients about psoriasis contributed to outcome effectiveness because it enabled them to achieve emotional distance from their disease and to increase their sense of control. Indeed, the lack of control over their

condition felt by patients with psoriasis is an important factor associated with greater psychological morbidity (Magin et al., 2009). Similarly, in their qualitative study, Fox et al. (2007) found that the struggle of patients to control their disease had a negative impact upon appearance, affecting self-confidence, social functioning, and perceived stigma.

Using the same participants' information, Fortune et al. (2004) conducted another controlled study on the effectiveness of CBT for psoriasis. This time, they also assessed the influence of alexithymia because patients with psoriasis are found to score higher on measures of alexithymia than controls are (Allegranti, Gon, Magaton-Rizzi, & Aguglia, 1994; Fortune, Richards, Griffiths, et al., 2002). The term 'alexithymia' refers to an absence of words for emotions; it was introduced as a concept by Sifneos (1973). People with alexithymia find it difficult to acknowledge their innermost feelings and therefore cannot employ words as signals of emotional stress (Taylor, Bagby, & Parker, 1997). Their inability to distinguish between emotional and physical sensation influences illness beliefs and their ability to engage in the treatment (Tacon, 2001).

The results of the study showed significant differences in illness beliefs about symptoms, about the severity of the consequences of psoriasis and the strength of beliefs in emotional causes between the two studied groups suggesting that cognitions maybe a key factor for psychological improvements. However, coping was not affected. Results also failed to support any significant effect of alexithymia on outcome. Interestingly, one third of alexithymic patients dropped out during the course of treatment and this relatively high attrition number cannot be ignored. Early loss from a randomised controlled trial (RCT) study, such as this one, may confound the results

and restrict the conclusions that can be drawn (Roth & Fonagy, 2006). One might raise questions about the delivery of the therapy *per se* in light of this high attrition rate. Interviewing this sample would have led to a greater understanding of the treatment process and would have explained what individuals needed from their therapy. Asking individuals about their needs from therapy and tailoring interventions to these needs can actually increase adherence to treatment and reduce attrition.

Overall, different aspects of the same study have been reported in these two papers. The authors found CBT to be effective and attributed improvements to the techniques used and to the didactic character of the PSMP. This study is considered to be “the gold standard” in terms of design and methodology because it adopted a Patient Preference Randomisation (PPR) design, in which participants could choose to either sign up for the PSMP or for standard treatment. Ward et al. (2000) suggested that the PPR approach, although inferior to RCTs (Green et al., 2008), be widely used in mental health studies because it correlates with motivation to adhere to the particular intervention (Brewin & Bradley, 1989), keeping differences between groups to a minimum.

Bundy et al. (2013) studied the effectiveness of the first web-based CBT approach for individuals with psoriasis. Research suggests that the use of computerised CBT is effective and feasible for a variety of psychological conditions because access to psychological treatments is problematic, due to increasing demand and long waiting lists (Spek, Nyklicek, Cuijpers, & Pop, 2008). Researchers used a randomised trial and recruited 135 patients from the waiting list. The intervention included management of self-esteem, stress and tension, negative thinking styles,

depression, coping, and psychoeducation. Results showed a significant reduction in the anxiety scores and improved QoL but failed to show changes in depression and psoriasis severity. In this study, the retention rates were disappointing, which could be attributable to the lack of one-to-one contact with the therapist (Williams et al., 2001).

### **Review of Psychological Interventions for Psoriasis**

Early psychological interventions for the management of psoriasis have employed small samples based on single-case experimental designs without evaluating the outcome of the intervention after the termination of therapy, (i.e., taking a follow-up measure) (Papadopoulos & Bor, 1999). Over time, the methodological rigour of trials in this field has improved, as attempts have been made to investigate the efficacy of psychological interventions by employing larger samples and using RCTs.

Fortune, Richards, Griffiths, et al. (2002) and Fortune et al.'s (2004) study, which targeted cognitions, shows improvements in physical and psychological outcomes. RCTs are considered to be highly influential in Evidence-Based Practice (EBP); they influence and guide decisions on funding and policy-making bodies (Cooper, 2008). However, the results of RCTs should be approached with caution for a number of reasons. First, RCTs adopt a position that is positivistic, conceiving of only a single truth that can be deduced through hypotheses-testing (Birks & Mills, 2011). Second, RCTs are considered inappropriate for dealing with complex social issues and their outcomes do nothing to explain why an intervention has failed or succeeded (Pawson & Tilley, 1997). Life is often much “messier” and mental health presentations with psychophysiological difficulties, such as the ones seen in psoriasis, are much more complex than

RCTs might lead us to believe. Routine practice, in which clients talk about a diverse range of experiences that do not fall neatly into one category (Copper, 2008), is therefore much closer to “post-modern paradigms whose criteria should be used when evaluating complex, real life evidence” (Watson, 2003, p. 162). Thus, it is essential to be aware of how we legitimise and value research evidence and not to devalue interpretive findings as poor evidence for practice because they do not sit at the top of the hierarchical pyramid, as RCTs do. In addition, one should be aware that RCTs primarily assess whether or not an intervention is effective without explaining how (Robson, 2011), which is a central aim of the current study. The message is that RCTs and EBP research should not be avoided, because they have an important role in research, but they cannot provide all the answers to all research questions. This study examined the perspectives of a group of patients with psoriasis who underwent CBT on what they had personally found useful in their therapeutic intervention in order to provide answers to what contributes to the outcome of undergoing CBT as an adjunct to medical treatment. It paid great attention to the real world of routine clinical practice, contributing in this way to the Practice-Based Evidence (PBE) paradigm. In order to achieve it, CGT was employed because this method explicates the factors contributing to the outcome of CBT from participants’ perspectives contextually, with the aim of generating a theory directly abstracted from and grounded in data.

Lastly, the relatively high attrition rate reported on the majority of the studies described above needs attention. Several different reasons for dropping out of therapy have been reported, from environmental constraints to being dissatisfied with their therapist or their progress, to several elements of the psychological interventions (Cooper, 2008). Studies on the psychological management of psoriasis have not explored this in depth. It is worth understanding the

individuals' perspectives of their therapy and reaching an in-depth understanding of their world. The clients' input in this regard would be an invaluable source of information and a qualitative approach could further assist this exploration. As Rennie (1994) and McLeod (2001) have suggested, qualitative approaches focus on subjectivity, allowing clients to articulate and contextualise elements of change important to them. In this way, therapists can develop a better understanding of what clients consider as useful in their therapy (Levitt, Butler, & Hill, 2006).

### **The Current Literature on the Effectiveness of CBT**

CBT is the most common and most researched intervention therapy method in psychotherapeutic research, receiving excellent press and occupying a central place in the move towards EBP (Sanders, 2010). It has the most substantial evidence base for its effectiveness for depressive and anxiety disorders (NICE, 2004, 2005). In particular, for anxiety disorders, CBT is found to be more beneficial than other psychological therapies (Roth & Fonagy, 2006). For depression, CBT has become one of the most practised treatments and its effectiveness has been shown in most efficacy studies (Seligman, 1995) including chronic medical conditions such as cancer (McGregor et al., 2004). For example, Radojevic, Nicassio, and Weisman (1992) reported reductions in inflammation and pain when treating rheumatoid arthritis using CBT. The existence of evidence to support CBT interventions makes this model of therapy a promising approach for ameliorating the psychological symptoms of a number of chronic medical conditions, including psoriasis. However, it is not yet known what makes it effective for psoriasis.

### **Literature on factors supporting the effectiveness of CBT.**

When considering factors that contribute to the outcome of a therapy, it has been suggested that the application of the intervention *partly* explains the variance in improvements across patients and that other factors beyond intervention affect the results (Cooper, 2008; Clarkson, 1995). This seems relevant; as Mearns and Cooper (2005, p. 3) argue, “the therapeutic change is not primarily the results of specific practices; rather there is a set of interpersonal factors responsible for this change across the whole spectrum of approaches”. Drawing from one of the world’s leading psychotherapy researchers, Lambert’s (1992) findings suggest that non-specific factors, such as client factors, relationship variables, and hope, account for 85% of the outcome in therapeutic outcomes, with only 15% being attributable to specific techniques or models.

Technical or non-common and relational or common aspects of therapy have been found to be an important variable in the understanding of the psychological process (Ackerman & Hilsenroth, 2003). Consequently, in the last two decades, a great deal of empirical research has been conducted in order to explore these findings further (e.g., Barber et al., 1999; Horvath & Luborsky, 1993; Martin, Garske, & Davis, 2000). Common factors refer to the “process” of therapy and how therapeutic interventions are implemented, and technical factors refer to the actual “content” interventions used (Goldman, 1954, p. 1). Common factors include the relationship components of therapy, such as rapport, trust, and collaboration. They serve as the foundation for improvement, being responsible for a large percentage of the therapeutic change (Ilardi & Craighead, 1999). Seminal authors in this field have found the therapeutic relationship to be the most important factor contributing to change (Levitt et al., 2006). Others have found many different factors, such as reflexive self-examination (Rennie, 1992), processes of defence or covert resistance (Levitt, 2001), clients’ intentions and feelings, therapists’ intentions and

style of relatedness (Elliott & James, 1989), the therapy environment, therapists' characteristics, and specific therapeutic interventions, such as therapist challenging, questioning clients, behavioural interventions, and the use of homework.

Examining these factors in further detail, therapists' performance has been suggested as a major contributor to outcome (Beutler, 1997; Roth & Pilling, 2008) and research has started looking at what therapists actually do. Results have shown that therapists of any modality need to demonstrate common skills, such as working ethically, knowing about the applied model, forming a good therapeutic relationship, and delivering techniques in a collaborative manner (Lambert & Ogles, 2004). Additional skills include basic counselling skills, such as nodding, summarizing, repairing therapeutic ruptures, and mapping out a developmental conceptualisation with the client (Bennett-Levy, 2006).

Therapists' qualities, such as warmth, empathy, and the instillation of confidence and trust, have also been considered to be strongly associated with a better outcome (Ackerman & Hilsenroth, 2003). These qualities influence patients' involvement in their treatment (Levitt et al., 2006; Williams & Chambless, 1990), which consequently acts as one of the most important determinants of outcome (Orlinsky, Grawe, & Parks, 1994). Empathy in particular has been found to be more essential for CBT than for other therapies that mainly use therapy relationship and, secondarily, technical interventions as the primary mechanism of change (Bohart, Elliott, Greenberg, & Watson, 2002). Further therapist qualities, such as impartiality, a non-judgemental stance, sincerity, and caring, were seen as significantly important when exploring clients' perceptions of change (Jinks, 1999). In addition, a therapist's support (i.e., complimenting the

client, seeking positive qualities, and showing encouragement) is also experienced positively by clients. This is found to develop feelings of trust (Fuller & Hill, 1985) and facilitates the process of treatment procedure and change (Schaap, Bennun, Schindler, & Hoogduin, 1993).

Another well-examined critical common factor that has been found to be the most important factor for change for most types of psychotherapy is the therapeutic relationship (Safran & Muran, 2000). The therapeutic relationship was originally ignored in CBT, with the focus placed primarily on technical aspects of the therapy and less on the relationship (Beck et al., 1990). However, during the last two decades, there has been increased interest in the nature of the therapeutic relationship in CBT (Gilbert, 1992; Safran, 1998), with a large body of studies supporting the therapeutic relationship as an active ingredient of change and as an integral part of a successful CBT outcome (Newman, 2013; Raue & Goldfried, 1994; Safran & Segal, 1996; Woo, 2011; Young, Klosko, & Weishaar, 2003).

Within the therapeutic relationship in CBT, collaborative empiricism is found to be a form of interaction (Beck, Emery, & Greenberg, 1985). This is a CBT notion according to which therapists help clients learn about themselves for themselves by structuring therapeutic conversations in such a way that it helps the client to take an active part. This is a shared responsibility, which stresses the importance of working within a mutual framework. In order for this to happen, therapists should be genuinely warm, emphatic, and open, and should not play the role of the expert (Roth & Pilling, 2008). Examples of CBT collaboration include establishing a mutually agreed agenda, monitoring thoughts and behaviours, and using homework tasks in a collegial manner (Johnsen & Friborg, 2015).

Besides relational factors, technical factors have also been found to contribute to the CBT outcome, with automatic thought records and behavioural experiments being considered the most valuable and effective elements in therapeutic progress (Bennett-Levy, 2003). Behavioural experiments are valued over thought diaries because they are more effective in promoting both behaviour and belief change (Bennett-Levy, 2003), as well as “offering the most powerful means to cognitive change” (Wells, 1997, p. 78) because they impact on different cognitive subsystems (Teasdale, 1997). Careful Socratic questioning and regular client feedback are strategies that have also been considered effective because they promote empathy and assist the therapeutic relationship (Thwaites & Bennett-Levy, 2007).

In summary, studies on process and outcome suggest that interpersonal and technical applications interact in forming a positive alliance influencing treatment results. Several studies concluded that the relationship and the therapeutic techniques are not separate domains but integrated aspects of a single process (e.g., Wright & Davis, 1994), and only in this way can the optimal treatment be provided (Trepka, Rees, Shapiro, Hardy, & Barkham, 2004). Indeed, seminal authors in the field of psychodermatology have acknowledged the possible impact of other factors, such as motivation for change, expectations, the therapeutic relationship, and trust, as contributing to and influencing the effectiveness of the outcome of psychological interventions (Fordham, Griffiths, & Bundy, 2013; Fortune et al., 2005; Walker & Papadopoulos, 2005). This is in line with counselling research, since within this field the same common factors have been held to be the primary determinants of therapeutic change since the 1930s (Cooper, 2008). However, for individuals with psoriasis who have received CBT usually as adjunct to their medical treatments, it is not yet clear as to which factors influence treatment outcome

because such research has not yet been conducted. Further investigations are therefore needed to explore the underlying mechanisms of change and any process variables, if any, underlying the therapeutic encounter in CBT. Addressing this gap in the literature is the main purpose of this study. CGT is regarded as an appropriate method for this exploration because it (a) helps contribute significant knowledge to an area of the discipline where little is known and (b) identifies relationships in the study arena and values processes as central elements of this arena.

### **General Conclusions and Rationale**

The literature review has suggested that psoriasis has a multi-faceted nature, meaning the effects go beyond the symptoms, putting a considerable burden on the individual's emotional well-being. An accumulating body of evidence suggests that CBT techniques may be the most effective in ameliorating the psychological distress resulting from living with psoriasis, although the mechanisms behind this outcome are not known. Studies have shown that common and/or technical factors account for therapeutic change. To the best of the author's knowledge, there has not been any study exploring the factors or any other countless factors that could influence the treatment process and impact on CBT outcome for individuals with psoriasis.

So far, studies examining the effectiveness of psychological interventions for psoriasis have employed quantitative designs focusing on quantification, accuracy, and precision of measurement and adopting a deductive logic by which pre-existing theoretical ideas are tested. In this way, a focus on meanings and understandings of phenomena in their setting, in which an inductive logic is used and there is little or no use of numerical data but descriptions from the perspective of those involved, is lost (Robson, 2011). Psoriasis and the therapeutic process can

be experienced differently by each individual and different factors might be perceived by them as useful or less useful in their treatment. By contrast, the adoption of a social constructionist paradigm, such as CGT, in which there are as many realities as there are participants and in which meanings are constructed by human beings as they interact and engage in interpretation (Robson, 2011), allows for the acquisition of multiple perspectives. A Grounded Theory study involves going out into the field to collect data several times (Glaser & Strauss, 1967), which differs from a traditional, linear one-way model of research, helping the researcher to understand phenomena that are complex and puzzling. Such a study goes beyond descriptive analysis by generating theory, adding further to what we know and improving our understanding of it (Corbin & Strauss, 2008). Such a qualitative method was considered appropriate for this study, which aimed to generate a theory based on clients' perspectives. Producing knowledge based on routine practice of what is perceived as useful by this clinical population makes this qualitative investigation instrumental because it can produce insights and better inform clinicians to design and implement specific methods to cultivate better alliances and treatment outcomes with their clients.

Given that the effectiveness of a psychotherapeutic intervention is generally considered attributable not only to the techniques used but also to common factors (Clarkson, 1995; Mearns & Cooper, 2005), a qualitative investigation in this field can be of great importance because it can produce significant insights into how, if at all, any common or other factors may contribute to the outcome of CBT for this group and produce knowledge based on routine practice. This is also in line with the practice of Counselling Psychology as it "continues to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry"

(Division of Counselling Psychology, 2006, p. 1). Counselling Psychology as a discipline cares about clients' assessments of their therapy experience and therefore seeks their feedback, which can guide therapeutic interventions and inform therapists' theories (Seligman, 1995). The present study aims to address this gap in the literature in line with the aforementioned principle and thus promote a scientist-practitioner model of practice.

### **Research Aims**

The study aims to identify the factors contributing to the outcome of CBT for individuals with psoriasis when used as an adjunct to their medical management. To date, no published research has explored CBT's outcome for managing the psychological symptoms of psoriasis on the basis of subjective accounts from those who received a course of CBT in order to understand better how these individuals perceived a therapeutic change, if any, and how they understand it to have happened. Findings will generate new knowledge in the form of theory and will expand our understanding about the CBT interventions and any other factors that might contribute to the treatment outcome. The information obtained is intended to inform clinical practice and help healthcare professionals that manage patients with psoriasis. Such information will also inform efforts of reducing costs in NHS adult health services across the UK and will enrich the field of practice-based evidence (PBE) research for service provision, which is currently very poor.

### **Originality**

No published qualitative research has been conducted investigating individuals' with psoriasis perceptions on the factors contributing to the outcome of CBT when used as an adjunct to medical treatment for psoriasis. Unpublished doctoral theses and anecdotal literature have been searched through university and national library databases and no relevant research in this area

has been found. This is therefore the first qualitative research that aims to understand the factors that account for therapeutic outcome by exploring individuals with psoriasis' experiences of CBT.

### **Reflexive Statement<sup>5</sup>**

As reflexivity has a crucial role both in CGT and in Counselling Psychology, I tried to be reflexive throughout the research process by being open to my own experience, sensitive to previous knowledge about the topic, and conscious of how this might have influenced the data (Charmaz, 2006). This section will therefore help the reader understand the processes that have contributed to the study as well as the subjective and intersubjective factors that have led to the co-construction of a theory between me as a researcher and the participants (Charmaz, 2006).

When reflecting on the choice of this particular topic, it was mainly a personal interest that prompted me to explore this area. This interest has been shaped not only by my experience of working in a psychodermatology service but also by having a close family member living with the symptoms of psoriasis. I have witnessed first-hand what it is like to live with this skin condition and the stigma attached to it. This lived experience has sparked a general interest in skin conditions, but more specifically in the therapeutic ways of managing them. My Counselling Psychology training increased my interest in the importance of the well-being and empowerment of the individual by finding effective ways to reduce psychological distress (Woolfe, 1996b).

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<sup>5</sup> The reflexivity sections will be written in the first person in order to address the researcher directly.

Clinical experience has helped me become aware of the limited provision there is for supporting individuals with psoriasis. Bewley, Fleming and Taylor (2012) concluded that there are only a few services in the UK providing psychological support. Individuals with psoriasis talk about clinicians' failure to recognise mental health concerns (Fortune et al., 2005). In particular, they comment on the limited support and unsuccessful medical treatments they received prior to visiting a specialist centre for their disease. It was felt that there was not only a need to promote support and treatment for these individuals but also to promote service users' voices because they have been inadequately represented. Patients should not be passive recipients of evidenced treatments (Corrie, 2010) but active and independent individuals with valuable feedback to offer and recipients of therapy tailored to their needs. Therefore, my intention was to generate a theory that explains this phenomenon of interest to me and move my analytical processes beyond simple description through exploration, contributing to theory in the disciplines of Psychodermatology and Counselling Psychology. My theoretical sensitivity to the area, based on my experience, made the choice of CGT a valuable one, because it allowed me to generate a theory while acknowledging my existing assumptions, using my knowledge effectively in identifying theoretically significant concepts and maintaining an open mind to new concepts.

Coming from a person-centred background, I have always valued the Rogerian core conditions and the importance of the therapeutic relationship. My CBT-orientated Doctorate in Counselling Psychology, which came later, gave me an appreciation of a collaborative yet directive, goal-oriented, and structured approach when working with clients. The combination of these approaches has helped me work within humanistic values and to interact collaboratively with clients, offering some skills that are more technical, in order to understand better participants'

subjective experience and to promote change (BPS, 2010a). My own experience as a trainee Counselling Psychologist has influenced my thinking around this area and has made me enter the research process with the expectation that a variety of different factors are possibly present in therapy and that different elements of it may be more/less helpful for the patients. Consequently, the use of CGT approach has helped me to value the individuals' felt therapeutic experience and to give them the space to voice their stories in order to gain a better understanding of what works in therapy according to them. Such an approach is in line with Counselling Psychology's values, according to which there is a commitment to critically reflect on practice and to use research and theory to inform and enhance it. Based on participants' perspectives of what they had personally found useful in their CBT sessions, this study has attempted to bring closer a fruitful partnership between research and practice.

## **Methodology**

### **Overview**

This chapter provides a description of the methodological approach used for this study. The first section describes how the study is situated within the qualitative research framework. This is followed by a description of CGT and the rationale for choosing this method. This chapter also describes how CGT is located within the broader framework of qualitative methodologies and within Counselling Psychology. Research procedures, the design of the study, and ethical considerations of the study are all also outlined in the following section. The last section presents the researcher's position and its relevance to this study.

### **Rationale for Using Qualitative Methodology**

This study's overall aim was to explore the perspective of individuals with psoriasis who underwent a course of CBT and, through this, identify the factors that contributed to the outcome of this therapeutic approach when it is used as an adjunct to standard medical treatment. In order to achieve this, a qualitative methodology has been chosen for the following reasons. Qualitative research underpinnings include an interest in understanding people's lived experiences and the meanings they bring to the researched phenomenon as it naturally occurs (Barker, Pistrang, & Elliott, 2002; Denzin & Lincoln, 2005). It provides rich accounts of the phenomena under investigation (McLeod, 2003) and tries to gain insight into individuals' subjective experiences by unlocking perceived meanings (Barker et al., 2002). Moreover, it is concerned with the way people make sense of the world and is curious about how and what individuals know (Patton, 1990). It is not concerned with the quantification or the measurement of a particular attribute in

large numbers of people (Langdridge, 2004). Instead, its fundamental goal is to uncover and shed light on what things mean to people by describing the latter's understanding of those concepts or phenomena (Willig, 2008). Therefore, a qualitative methodology that focuses on the way individuals experience events and make sense of the world through exploring, describing, and interpreting personal and social experiences (Smith, 2003; Willig, 2001) was considered suitable.

Qualitative methodology has also been proposed as being useful when the topic under investigation is characterised by a lack of prior research or theory (Jones & Alony, 2011; McLeod, 1996). The results of the literature review revealed that this topic is not sufficiently developed. Therefore, given the limited research on this field and specifically on the factors that contribute to the outcome of CBT for individuals with psoriasis, a qualitative design was deemed appropriate to provide an exploratory approach.

A qualitative methodology has been chosen due to its philosophical underpinnings. It is rooted in an ontological and epistemological perspective according to which there is no single way of perceiving reality but instead many realities, and each individual subjectively makes sense of his/her own. From this perspective, realities are socially constructed by individuals' experiences and the meanings they attribute to them. This philosophy highly values the complexity and diversity of individual experience and has been adopted for this study because it is consistent with the study's aims, which focus on individuals' understanding of reality without reducing it to numerical forms.

This view is also consistent with social constructionism, a post-modern philosophical movement according to which there is no unitary way of perceiving reality because multiple, constructed realities may co-exist (Gergen, 1985). Social constructionism places great emphasis on the language and meaning that gives rise to multiple realities (Barker et al., 2002) and views meaning-making as a relational activity (McNamee, 2004). This position is coherent with the principles of CGT, which has been used as the method of data analysis and will be delineated later.

Furthermore, this epistemological perspective abides by the researcher's philosophical stance; that is, having an interest in exploring multiple viewpoints about a subject through hearing and understanding the way participants make sense of their experiences. This stance has been shaped by her training in Counselling Psychology, a discipline that places at its core the subjective experience of individuals. As a result, the researcher felt naturally drawn to this approach, within which she can explore and engage with the multiple meanings and views of individuals with psoriasis concerning CBT.

In addition, a qualitative perspective has been chosen as it acknowledges the important role the researcher has in capturing multiple viewpoints through engagement with participants on an individual level (Silverman, 2009). This seemed important for the researcher as within this paradigm, and with the aim of gaining deeper understanding of individuals' experiences, the researcher participated in data generation and creatively affected—and was affected by—the range of participants' experiences and views. In this circular process, which sees the researcher dynamically interacting with the research phenomena (Willig & Stainton-Rogers, 2010),

reflexivity is encouraged and the researcher's reflections on the dynamic interactions with the research phenomena are an additional valuable source of data in the development of new theories (Flick, 2002).

In summary, given the characteristics of the research question, it seemed most appropriate to employ a method driven by a focus on subjective meanings in order to explore how individuals with psoriasis make sense of CBT when used as an adjunct to their standard medical treatment. Such an experiential and reflexive approach not only encourages the researcher's impact on the research process but also views the researcher's reflections as a source of data influencing theory production.

### **Rationale for Using CGT**

This study followed Charmaz's (2014) constructivist version of Grounded Theory. Grounded Theory is a qualitative research design that focuses on producing theory that is directly grounded in the data. It is situated to study individual processes and experiences "related to the social context within which they occur" (Pidgeon, 1996, p. 75) by providing rich descriptions of data (Strauss & Corbin, 1998). Moreover, Grounded Theory is characterised by a dynamic process of continual sampling and constant comparisons between the data and the researcher's developing conceptualisations (Charmaz, 2006). It uses methods of subsequent refinement of its findings and expanding data categorisations, which lead to the construction of a theory.

Unlike traditional Grounded Theory, Charmaz's constructivist version places great emphasis on the interaction between the investigator and the participant. CGT adheres to a constructivist

paradigm that assumes there are as many apprehendable and equally valid realities as there are participants and researchers, whose meanings are often co-constructed (Ponterotto, 2005). In particular, Charmaz (2000, p. 254) claims that, “data do not provide a window on reality; rather the discovered reality arises from the interactive process between the researcher and participants”. Such a position is consistent with the aims and the post-modern philosophical position of the current study, which attempts to capture the views and multiple meanings held by individuals with psoriasis and believes in the researcher’s active participation in the creation of data generation.

In this interactive researcher-participant dialogue, the researcher’s subjectivity has an integral part in the research (Morrow, 2007). In order to keep researcher’s standpoint and identity secondary, reflexivity is used within this version of the theory. Reflexivity helped the researcher become aware of her personal and professional assumptions, and her biases in interpretation of data and processes. This is also in line with Counselling Psychology’s values, which emphasise the importance of being reflective and aware of one’s own processes (BPS, 2010a). As a result, the validity of the results has increased, giving the work a degree of scientific rigour (Glaser & Strauss, 1967; Yeh & Inman, 2007).

### **CGT and Counselling Psychology**

Counselling Psychology’s foundation on a post-modern, pluralistic, and integrative philosophy (Woolfe et al., 2007) is found to parallel the broader aims and philosophy of this CGT project. Counselling Psychology is a humanistic discipline that places at its core the subjective and intersubjective experiences of the individual and focuses on understanding the subjective world

of the self and other (Strawbridge & Woolfe, 2003). Similarly, CGT seeks to understand and gain insight into participants' experiences, which are respected as meaningful and valid in their own terms, and tries to make sense of these by understanding and giving voice to each of the participants (Charmaz, 2014). In particular, through constant comparison and rigorous analysis, CGT is always alert to differences and distinctions between people and tries to analyse each experience in detail in order to make sense of it and develop a theory (Charmaz, 2014).

Moreover, Counselling Psychology's relativist ontology is based on the principle that there are multiple realities in which meanings are constructed by clients and therapists; in other words, by participants and researchers (Morrow, 2007). Likewise, CGT's constructivist-interpretivist paradigm assumes that there are multiple realities in relation to which meaning is conveyed through dialogue and action and interpreted by both observer and participant (Jones & Alony, 2011). It also assumes that theories are co-constructed by both the researcher and participants, with the aim of theory building and facilitation of a more deductive, verifying approach. It does not rely on the authoritative voice of the researcher; instead, it constructs reality, with the participants avoiding predetermined views of individuals' experiences (King & Kitchener, 2002).

An important principle of Counselling Psychology research is to support research that informs clinical practice (McLeod, 2003). Similarly, CGT constructs theories through rigorous analysis that aim to inform policy and practice (Charmaz, 2014). This design has helped the researcher investigate elements that contribute to the outcome of CBT for individuals with psoriasis and develop a theory that can inform practice.

In addition, what distinguishes CGT from other methods is its emphasis on analysing actions and processes. This principle was thought to be consistent with the present enquiry, which aims to explore therapeutic factors and processes that facilitate well-being and which eventually may support people in distress. This is in line with Counselling Psychology's historic emphasis on the world of the client and on a non-pathologising approach (Woolfe, 1996b).

Lastly, CGT offers flexible guidelines that allow the researcher to go back and forth between data and analysis (Charmaz, 2014). It provides methods and tools to construct theory without following methodological recipes or mechanical processes. Like Counselling Psychology, in that it emphasises subjectivity, looks beyond guidelines, and accommodates the protocols to fit clients' needs and not vice versa, CGT remains open to theoretical possibilities, novel understandings, and the unexpected, aiming to develop theories generated from a multiplicity of perspectives.

Thus, it seemed appropriate to choose an approach and method in line with the overarching principles of this study's philosophical and professional stance, following Richardson's (2001) suggestion that the choice of a research approach is dependent on the researcher's professional orientations.

### **Constructivist Grounded Theory Versus other Qualitative Methods**

Other qualitative approaches were also considered for this study but there were a number of reasons that led to the choice of CGT as more suitable.

Interpretative Phenomenological Analysis (IPA) was given consideration because it is also concerned with understanding how the individual experiences the subject under investigation (Smith, 2003) and places great emphasis on the researcher's interpretations of the data. However, IPA's detailed emphasis and focus on examining the subjective meaning of a lived experience rather than the processes would create results based only on subjective phenomenology and therefore provide the researcher with more interpretative and less explanatory accounts of the participants' views of their CBT treatment. Given that this research is concerned with the study of processes, it was decided that if IPA had been utilised it could have potentially offered only a detailed understanding of patients' subjective experience of their CBT treatment (McLeod, 2001). It would not have helped produce any insights into the mechanisms of the therapeutic processes of CBT, which was the aim of this research study. Another reason for rejecting IPA was the simple analytic method that IPA adopts and its minimal emphasis on generating an overarching theory based on the emergent data. Considering the aims of this study, one of which is to generate a theory based on similarities, differences and connections among the CBT experiences of participants with psoriasis, IPA was not well suited.

Discourse analysis is a qualitative approach that places great emphasis on participants' discourse, examining what people do with language and how they construct their social reality (Willig, 2008). It was felt that Discourse Analysis' primary emphasis on language use in social interactions would have produced findings based on a microanalysis of the language used by the participants. However, it would not have enabled an in-depth exploration of patients' meanings and views related to their CBT treatment, nor would have it allowed for the construction of an inductive theory as CGT would. Instead, the focus would have been on the linguistic resources

participants used during their interviews, and the way they used them, rather than on the construction of a theory and study of their CBT therapeutic process. Therefore, Discourse Analysis was not a good fit for answering the research question.

Thematic Analysis (Boyatzis, 1998) is another qualitative approach whose deductive characteristics, in the form of classification and organisation of data under a pre-defined set of thematic headings, made it rigid and inflexible to use for the particular research question (Braun & Clarke, 2006). CGT's more flexible and fluid character, which resists the mechanical application of research, was felt to be more consistent with the explanatory and the theory-construction nature of the research question. Thematic analysis would have produced conceptually informed interpretations of participants' accounts of CBT, but it would not have attempted to develop a theory nor would it have focused on therapeutic process or influencing factors with the aim of providing a theoretical conceptualisation of CBT with psoriasis. Additionally, Thematic Analysis does not stem from a particular theoretical or epistemological framework that anchors the analytic claims made. Nor does it require the detailed theoretical and technical knowledge of an approach such as CGT. Therefore, it has limited interpretative power beyond mere description. In contrast, CGT is itself considered a theoretical framework that generates a substantive theory and yields more sophisticated and insightful results (Charmaz, 2006; Young Cho & Lee, 2014).

Therefore, of the aforementioned considered methodologies, CGT was deemed the most appropriate for enabling the investigation of the views and experiences of participants as they

relate to their therapeutic context, the exploration of therapeutic processes and actions, and the production of a theory that could inform policy and practice.

## **Research Procedures**

### **Process of referral to the Psychodermatology Service.**

Participants of this study came from a dermatology service of a teaching hospital in England. This dermatology service is a secondary care service, referrals to which are made by each patient's GP because, typically, patients with skin conditions are initially managed under primary care. Depending on their symptoms' severity, patients either remain under the GP's care or, if their symptoms worsen, eventually are referred to this dermatology service where they receive longer-term treatment, such as systemic therapy or phototherapy, according to their needs.

The Psychodermatology clinic is a dedicated psychology service for all skin patients and runs alongside routine dermatology clinics. Consultant dermatologists routinely assess the severity of the skin conditions through questionnaires. In particular, for psoriasis, they use the PASI and screen the patients for their distress and quality of life through standardised scales such as the HADS and DLQI. Depending on patients' scores and their clinical interview, the dermatologist can suggest a referral to the Psychodermatology service. The clinician educates the patient about the referral and explains the Psychodermatology service. Additionally, patients with psoriasis are told they can attend weekly meetings during which the dermatology team offers further information about their condition and the Psychodermatology service. After these meetings, patients can discuss their needs further with the clinicians who can arrange a referral to the Psychodermatology team.

Patients who accept to be referred are offered an initial screening and assessment consultation conducted by the lead psychologist within four to six weeks of the referral. During this appointment, the patients discuss their concerns and the reasons they were referred for psychological support. The psychologist then decides whether patients are indeed an appropriate referral and explains how the service could help them overcome or better manage their difficulties. After this initial contact with the psychologist, the patients have at least six to eight months to commence their psychological therapy. In the meantime, they continue to attend their follow-up appointments with the dermatology team.

The Psychodermatology team consists of therapists (both male and female) who are a qualified Counselling Psychologist (service lead) and two to three Clinical/Counselling Psychologists in Training. The trainees have usually completed their first year of training of doctoral studies with CBT as one of the main therapeutic models of training. Their training programmes in Counselling or Clinical Psychology are approved by the Health and Care Professions Council and are accredited by the British Psychological Society. All therapists receive supervision from the lead psychologist of the Psychodermatology Service.

Within this service, therapists work within a specialist CBT framework that focuses on dermatological and appearance specific concerns. The interventions are based on cognitive-behavioural techniques, but the therapists do not use stringently defined and inflexible, manualised intervention procedures. Instead, they offer individually-tailored treatment protocols as informed by case formulations. Each patient offered psychological therapy receives a minimum of six and a maximum of 12 CBT sessions and post-therapy review sessions after 6

and 12 months. Throughout therapy, clinical evaluation of each patient's psychological progress takes place via standardised scales such as the HADS.

### **Recruitment.**

Participants were recruited from the Psychodermatology Clinic of a hospital in rural England where the researcher holds an honorary position as a Counselling Psychologist. Following NHS ethics clearance (Appendix C), participants who met the inclusion criteria for the study were initially contacted by the dermatologists involved in their care and were invited to participate in the study. The dermatologists explained to the potential participants the purposes of the study and gave them the study information sheet (Appendix D). The study information sheet was also emailed and/or posted to those who were contacted over the phone by the dermatologists. Potential participants were given some time to decide. Those who were interested in proceeding could contact the researcher directly by phone or e-mail. An appointment was then made with the researcher for the interview at a time suitable to them.

It is also worth noting that the patient recruitment process could raise ethical considerations that require our attention. Firstly, participants were invited to discuss their experiences with therapists who worked in the same department as the researcher. Secondly, the participants were informed about the survey by senior clinicians responsible for their care and treatment. This might have put pressure on certain patients to participate in the study, or made them wonder whether the researcher might share any of the interview feedback with her colleagues. Some participants might also have restricted their responses in order to avoid sounding overly critical or dissatisfied with their treatment, if at all. Or, equally, they might have given extremely positive accounts in

order to please their therapist and/or dermatologists. The above could have created a power imbalance confounding the results.

Therefore, measures were taken to minimise any adverse effect that could have influenced the participants' decision to participate in the study, and affected the research process. Firstly, none of the potential participants contacted were the researcher's previous patients. This way, feelings of obligation to participate or to share experiences in a way that satisfies their ex-therapist/researcher were minimised. Secondly, it was made clear that participating or not in the study would not have any adverse implications on current or future treatment they may require from either the dermatologists or the therapists. Lastly, participants were given a "Participant's Information Sheet" and a "Consent Form" that explained in detail issues around confidentiality, anonymity and the fact that only the researcher would have access to the patients' names and data (Appendix D, E). It was also explained that if any of the academic staff or supervisors wanted to access the data, they would not be able to identify who had said what, because personal details would not be revealed and pseudonyms would be assigned to every participant. To ensure that the participants had clearly understood issues around confidentiality, the researcher explained how pertinent this issue was, she gave them time to raise any concerns and went through the points of the consent form together with each participant before asking them to sign the form and start the interview. At the conclusion of the interview, and during their debriefing, participants were again reminded of the confidentiality and anonymity of the process.

### **Participants.**

Guided by the literature, discussions with the supervisor and Charmaz's criteria on conducting a CGT study, participants were selected according to the following criteria:

- i. Participants were older than 18 years of age.
- ii. They have been diagnosed by a dermatologist as having psoriasis for over a year.
- iii. They have completed a course of CBT as outpatients.
- iv. They have no enduring or severe psychiatric disorder (e.g., psychosis, bipolar, personality disorder).
- v. They have not been clients of the researcher.
- vi. They were fluent in English. This is because, in this type of exploratory analysis, language is the way that participants can communicate and describe their lived experience under investigation (Willig, 2008).

Anyone who did not fit the above criteria was excluded from participating and was given a debriefing information sheet (Appendix G). Nine participants were recruited. As a way of accounting for a wide range of psoriasis and degrees of psychological severity, participants with a variety of PASI and psychometric scores were recruited. Similarly, in order to account for the entire spectrum of therapeutic outcome, participants with variable end-of-therapy scores were included.<sup>6</sup> Table 1 (Appendix N) provides information on participants' demographics, psoriasis severity, and scores on psychological questionnaires that aided in the process of theoretical sampling by guiding the researcher to explore and identify areas of diversity that needed investigation.

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<sup>6</sup> Criteria for defining successful treatment were: (a) a reduction in HADS <10, (b) the participant had not dropped out from treatment.

### **The process of developing the interview schedule.**

Prior knowledge of the research topic through the review of the literature, in combination with the researcher's clinical experience, provided a starting point for the design of the interview schedule that fulfilled the research objectives. According to Kvale and Brinkmann (2009), formulating the research questions by obtaining pre-knowledge and theoretical understanding of the subject matter to be investigated is the thematising stage of an interview study, which helps the researcher answer the thematic questions of "why" and "what". This pre-knowledge stage helped the researcher adopt an approach of being theoretically sensitive rather than preconceived. Therefore, the researcher devised some broad and open-ended questions that could cover a wide range of experiences, yet narrow enough to explore and elaborate specifically on participants' views of their CBT experience.

In Stage 1 the researcher asked only a few general questions related to the participants' overall experience of CBT, their overall view of their therapist and the progression of their psoriasis (Appendix I). The preliminary analysis of the participants' accounts and the open coding of this stage generated some initial factors that were found to influence participants' therapeutic experience and required further exploration. In particular, the factors that stood out at that stage were the participants' attitude towards homework and the process of talking/expressing their emotional distress to their therapist. From the analysis, it also emerged that the therapist's qualities, such as being understanding and caring, as well as participants' positive experience of the dermatology team were factors that influenced participants' CBT experience. All these emerging factors from the analysis needed further clarification. The interview guide in a CGT study is a flexible tool that evolves over time as the grounded theorist engages in data collection

and data analysis (Charmaz, 2014). The researcher thus used the insights from the initial analysis and further developed the interview questions on Stage 2 (Appendix J).

The Stage 2 of the interview process included the interview questions from Stage 1, however more questions were added (i.e., Question 4, Question 5, Question 7, Question 8 and Question 10). These questions helped the researcher delve deeper into the participants' views and experiences of CBT and explore the extent to which the emergent codes from the previous stage describe the participants' experiences. In particular, the analysis from the data gathered from Stage 2 showed some interesting relationships between the categories (e.g., how the therapist's qualities impact the process of expressing emotional distress) and helped the researcher synthesize the prevalent codes from Stage 1 and 2. Additionally, at that stage the category of feelings of engagement, the importance of establishing a trusting therapeutic relationship and the category of the restructuring of the meaning attached to psoriasis were more clearly shaped. Yet these were incomplete and needed to be explored further. In order to gain greater clarity on the conditions under which the identified categories represent the participants' experience of CBT, further questions were asked on Stage 3 (i.e., Question 9, extra prompt questions on Q4, Q5, Q7). This last stage of the interview schedule (Appendix K) included questions that followed up on previous patterns (e.g., non-judgemental environment, attitudes towards homework, non-burdening emotional release) but also more specific ones, for example questions related to the impact of the cognitive work on the therapeutic progress. This stage helped the researcher see how similar and different categories compare with each other and further informed the subsequent data analysis by capturing and crystallising what others had indicated in earlier interviews.

Throughout the interview stages, the theoretical sampling informed the researcher what to accomplish in subsequent interviews and whom to ask for her next data. Based on the interview responses and on the emergent patterns, the researcher recruited both male and female participants with a range of psoriasis visibility, chronicity and severity of psychological distress. The participants also had a broad age range and degree of therapeutic effectiveness as measured by their psychometric scores.

Overall, the researcher tried to generate questions that contributed thematically to knowledge production by relating to the “what” of the interview and dynamically to promoting a good interview interaction by keeping the flow of conversation going and stimulating the participants to talk about their experience (Kvale & Brinkmann, 2009). The researcher always asked herself the fundamental grounded theory question of “What is happening here?” (Glaser, 1978), the answers to which helped her link the events and guide her subsequent interview questions. Equally importantly, the researcher shaped “what” and “how” questions to obtain rich material and not impose preconceived concepts on the participants’ accounts. For example, when participants spoke about the cognitive element in their CBT, instead of making assumptions about what this meant (e.g., automatically assuming that the participants were referring to developing an alternative cognitive perspective), more clarifying questions were raised such as “What did this experience mean to you?” These questions helped the researcher gain a more textured, dense understanding of the meaning attached to the participants’ experiences and specify the conditions under which the emergent concepts occurred or changed. The process of altering the interview schedule, developing new ideas about what questions to ask and going back out and asking more questions, helped the researcher understand that CGT was not a linear

process and that she needed to become more active as the interviews went along in order to successfully manage the alternation between research stages. Finally, it is important to point out that the development of the interview schedule, the initial analysis of the data and the subsequent generation of the interview questions are inevitably constrained by the researcher's choices. Other people would have possibly included other questions or would have potentially identified different emergent patterns from the participants' accounts.

### **Interview procedure.**

Interviews took place at one of the counselling rooms at the Department of Dermatology wherefrom participants were recruited. Prior to the commencement of the interview, participants were reminded of the purposes of the study, of the voluntary nature of their participation, their right to withdraw, and the confidentiality and anonymity of the process. Time was allowed for the raising of questions with the researcher and participants were then required to sign a consent form (Appendix E).

Each interview lasted approximately 50 minutes and was recorded on a Sony Digital Voice Recorder. Time was taken at the beginning of each interview to develop rapport by using warm-up questions. It was made clear to participants that the study was being conducted for academic purposes (doctoral thesis) and that only the supervisors and academic staff would have access to the data collected; no personal details would be revealed. Part of the consent process included agreement that quotes from the interview would be used in the write-up of the doctoral thesis and journal articles but all identifying information will be removed from the transcript and write-up. In this way, participants could not be identified.

Semi-structured interviews were employed because this style enhances in-depth exploration of participants' experiences "without overly directing participants or constraining them in pre-formulated questioning" (Pidgeon, 1996, p. 90). This interview process was also consistent with the ontological and epistemological assumptions of the present study, which considers people's views as meaningful features of the social reality. Charmaz's (2006) CGT approach also supports this interview style because it is open-ended but directed, and emergent but shaped. Therefore, it was considered the most suitable method for answering the research question.

There were three data collection phases. The first phase included a pilot study and two more interviews. The pilot study helped the researcher test the adequacy of the initial interview schedule. The findings of the interviews suggested some preliminary assumptions about concepts that needed further investigation. Therefore, in line with CGT (Charmaz, 2014), interview questions were modified and revised in light of developing categories. New questions that enhanced discovery of new ideas as well as exploration of initial findings, were added (Appendix J). At that point, on the basis of the initial findings, three more participants were interviewed. Following CGT guidelines, the transcripts were analysed and new amendments were made to the interview schedule, based on participants' responses and findings from previous phases in order to discover new ideas to those presented in previous stage (Appendix K). Three final participants were interviewed to explore the validity of previous findings and to account for the amendments made to the interview schedule. All participants were asked ending questions that prevented an abrupt ending of the interview process.

After completion of the interview, participants were debriefed and received a written debriefing form (Appendix F). They were also given time to ask any further questions and reflect on feelings and thoughts experienced during the interview. On consideration of any adverse emotional consequences, participants were provided with a contact point for further support if needed (Appendix F). No such need was expressed. Body language and verbal feedback indicated that all participants left the interview setting in a positive frame of mind. The distress protocol that was in place (Appendix H) was not used. Participants had the choice of reimbursement for any travel costs to the hospital for their interview.

#### **Ethical considerations.**

The proposal for this study gained full ethical approval from the London Metropolitan University Psychology Research Ethics Review Panel (Appendix B). Ethical approval was also granted by the NHS Research Ethics Committee (REC Reference: 13/EE/0416). The research was also undertaken in line with the British Psychological Society's Code of Human Research Ethics (BPS, 2010b).

#### **Data management.**

In order to immerse herself in the data, the researcher manually transcribed all interviews. The transcripts included all false starts and extraneous words that enhanced in-depth analysis. Data were collected and analysed within the NHS Trust. In line with the Code of Human Research Ethics (BPS, 2010b), all identifying features of participants were changed to protect privacy. A pseudonym was assigned to each participant, which appeared on all data. All of the information collected during the study, excluding names, was stored and analysed confidentially in a password-protected computer. No identifiers could enable a third party to link the data to a

particular participant. Informed consent forms were kept separate from the data in a different cabinet at the hospital (NHS Trust) and were secured under lock and key. The information will be kept for five years (in case of publication) and then will be disposed of.

### **Analytic strategy.**

According to Charmaz's guidelines (2014), all interview transcripts, including the pilot study, were re-read several times and were then coded line by line. Coding refers to the process whereby labels are attached to segments of data that relate to propositions about how the individuals perceive themselves, others, and the world (Charmaz, 2014). Following Charmaz's guidelines, the researcher analysed the initial data and used active codes, such as gerund-based phrases, utilising participants' own words. After a list of initial concepts was generated from the first interviews, the researcher conducted theoretical sampling. Theoretical sampling is a strategy that allows researchers to move back and forth between category and data so as to seek further information on the perspectives suggested by earlier analysis and achieve refinement and ultimately saturation of existing categories (Charmaz, 2014). This strategy helped to construct full and robust categories and specify relationships between them by providing interesting comparative information.

The next phase of coding was focused coding, a process in which the researcher selects a set of the most prevalent initial codes and uses them to synthesise and explain larger segments of data. After the researcher had identified the central focused codes, based on their frequency and significance, a re-analysis of all data was conducted to examine all available insights regarding those codes and the relationship among them. The final stage is the theoretical coding phase, in which all main categories and underpinning focus codes are integrated to form higher-level

analytic categories. A core category that seemed to capture the essential nature of participants' experiences and had the greatest links with other categories was then developed.

The process of constant comparison was employed throughout the coding and analysis stages. This comparative method is an iterative process that helps researchers to compare selections of data to each other in order to find similarities and differences within and between categories and generate more abstract concepts and theories. Once a category was identified, after a constant comparative method, the researcher looked for instances that did not fit the category (i.e., negative cases). This process indicated whether there was a need to refine the emerging theory in order to be able to "capture the full potential of complexity of data" (Willig, 2008, p. 36). The researcher looked for higher common meaning between categories; that is, a concept that would sit at the top of the conceptual hierarchy. After analysing the last data according to Charmaz's guidelines and discussing this in supervision, it was determined that theoretical saturation had been achieved. Theoretical saturation is a defining feature of CGT and refers to the point at which the addition of further data does not add further variability to the categories (Charmaz, 2014). In this study no more categories could be identified, nor could any additional insights about the emergent categories be produced. This process is demonstrated in an extract from a transcript in Appendices L and M.

The process of data analysis was further assisted by memo-writing and diagrams. Memos are widely used in the Grounded Theory method as a way of interpreting the results and reflecting on initial and focused codes emerging throughout the analysis. The researcher wrote extensive case-based memos recording reflections on the meanings of codes, comparisons between data, and

thoughts about the process as they occurred (Appendix O). Memos helped in making comparisons between data and finding similarities and differences, which also helped to identify gaps in the analysis. Constant comparisons among memos facilitated refinement of the categories and identification of emergent ideas that could be explored in subsequent interviews. Finally, at the end of data collection and the analysis, a tentative model of the factors that contribute to the outcome of CBT for psoriasis was developed.

### **Reflexive Statement**

This section is about reflecting on the data collection and on the factors that have influenced the analysis process, which subsequently led to the co-construction of a theory.

I position myself, epistemologically, with the concept of meaning as socially constructed. I espouse this approach, positing that language is important in the understanding of our lives and that individuals' sense of self is partly emergent from the communication process (Ponterotto, 2005). CGT, by which I was guided, accepts this stance and allows for multiple interpretations and realities. This approach gave me the opportunity to engage with the complexity and richness of participants' data and helped me provide a deep construction of their experience of CBT treatment rather than generate a breadth of data and discover the truths.

Reflecting on the choice of this particular approach, I realise that CGT has enhanced the process of developing a theory for the following reasons. It has provided me with the strategies to collect sufficient data, analyse and amalgamate them (Charmaz, 2005). I could therefore, move beyond a simple description of data and develop a theory (Corbin & Strauss, 2008). Additionally, its

iterative flip-flop process of going back and forth between data collection and analysis has enabled me to ask participants questions when aspects of experience appeared to be missing. It gave me the opportunity to be flexible enough to rework categories, collect more data, and reorganise my work to produce an abstract theory. In this process, I was careful to remain open to new categories emerging in subsequent transcripts and to amend my interview schedule accordingly.

The semi-structured interview style has also enhanced the development of a theory. It allowed me to engage the participants in a dialogue rather than dictate the direction of the interview. Because of this, participants had the maximum opportunity to speak freely about their experiences and I was able to follow their lead. At the same time, I was specific with my questions in order to cover the issues I wanted and was able to encourage participants to talk about their experience by being general and open-ended. This was a delicate process that needed great attention and balance. Retrospectively, I wonder how my experience of working in the Psychodermatology service—and my prior knowledge of the topic through the literature review—has influenced my research questions. I wonder whether my assumptions and expectations have manifested themselves through my prompts and the way I posed my questions because in a qualitative study, the researcher inevitably influences the research process and participants' responses (Finlay, 2002). However, in a CGT, theoretical sensitivity, constant comparisons and memo-writings ensure that the categories emerge from participants' accounts and do not merely reflect the researcher's preconceptions. The use of a reflective diary and supervision have also facilitated the process of analysis and reflexivity.

When reflecting on data collection, one needs to reflect on the dynamic of the relationship between the researcher and the participant and how their interaction has affected the interview. Drawing on my own experience, I assume that my dual professional role—as researcher and as a trainee Counselling Psychologist working in the department—may have affected, how the participants related to me. On the one hand, it has been suggested that the researcher’s familiarity with the field is a positive opportunity for increased understanding and sympathy towards the lived experience (Yardley, 2008). For example, I felt we had a good rapport because participants could relate to me well and were open and willing to talk about their experiences. On the other hand, I was struck by one interview with a participant who wanted reassurance of confidentiality when she spoke of her therapist in a less complimentary way, in her attempt to give “constructive feedback”. It is difficult to speculate, but had I not been part of the psychodermatology team, interviews may have been different with participants who had found therapy more challenging. Having said that, and on reflection, I realise that participants were themselves reflecting, giving me rich and nuanced data, and feedback regarding the interview material was positive. I also believe that by adopting an honest approach and letting the participants know about my position and that their treatment would not be affected, as well as by being ethically considerate, I minimised power differences, if any existed. I also avoided adopting an “expert versus learner” role in order to create a mutual environment of engagement, empathy, and emotional involvement (Morrow, 2007, p. 218). My role and skills as a trainee Counselling Psychologist have enhanced this process, as I was empathetic, non-judgemental providing a nurturing stance. This helped participants feel relaxed, engage well and reach a deeper level of trust and disclosure.

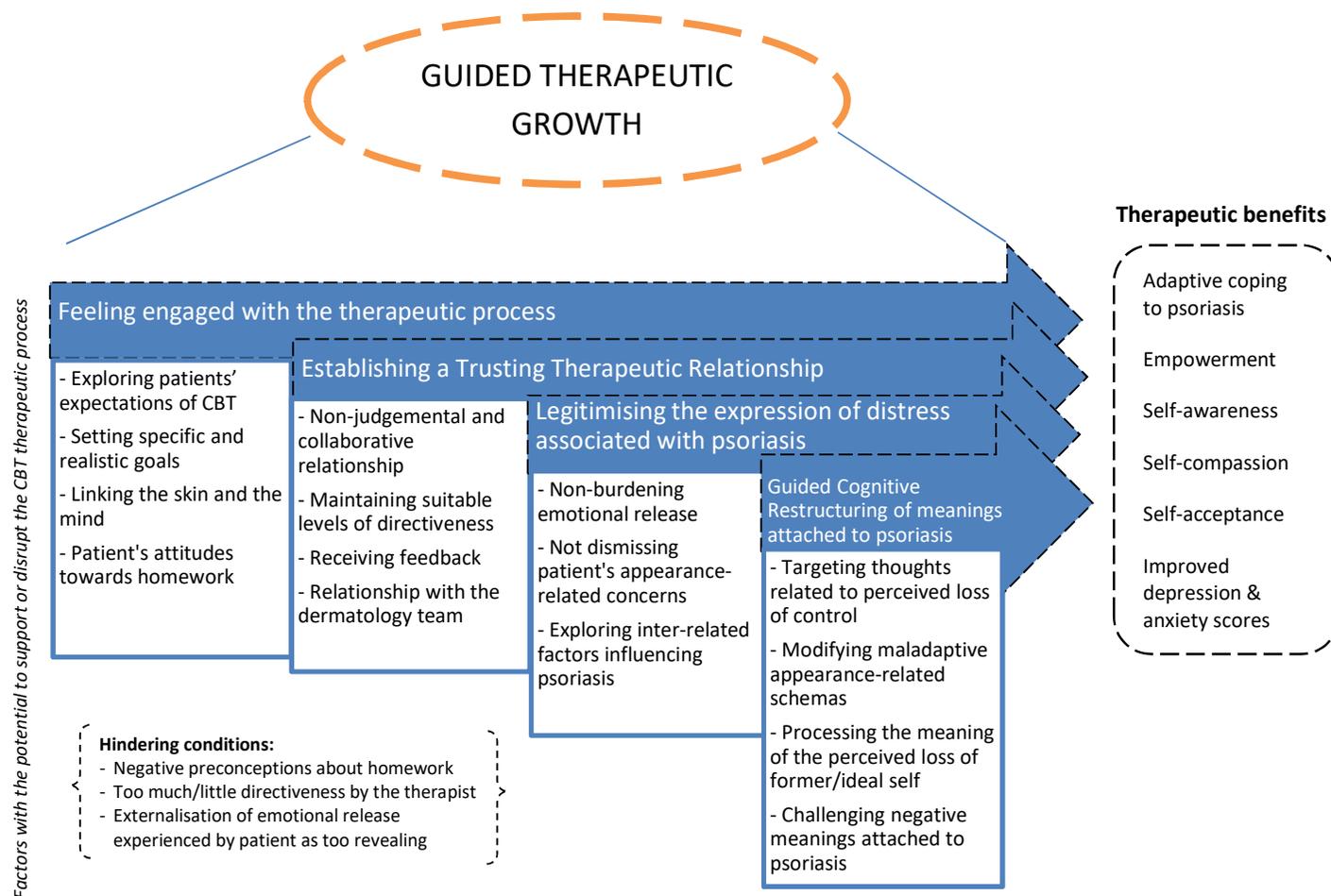
## Results

### Overview

This section outlines the emergent theoretical model of the factors that contribute to the outcome of CBT based on the nine participants with psoriasis accounts who had received a course of CBT as part of their medical management. The first section presents the overarching theory of Guided Therapeutic Growth and describes how the four identified concepts interact to form this overarching integrated theory. The second section describes in further detail these four key concepts as constructed and interpreted by the researcher. It also presents quotations from the participants and explains how the concepts were developed around the emergent core category of Guided Therapeutic Growth. The **concepts** will be presented in bold and the *categories* will be in italics.

### The Theory of Guided Therapeutic Growth for Individuals with Psoriasis

The concepts and categories that emerged from this Constructivist Grounded Theory analysis have provided a framework for organising and describing a theory, named Guided Therapeutic Growth. This theory is based on the accounts of nine participants and describes the factors that contribute to the psychological management of individuals with psoriasis when used as an adjunct to standard medical treatment.



**Figure 1. A Graphic Representation of the Constituent Parts that Form the “Guided Therapeutic Growth” Model for CBT for Individuals with Psoriasis**

Figure 1 depicts this theoretical proposition of how the process of Guided Therapeutic Growth with its interrelated factors contributes to the therapeutic outcome. As illustrated in Figure 1, the overarching category of Guided Therapeutic Growth, which also emerged as the core category, encompassed four major concepts that were notably interlinked and to some extent sequentially experienced by the participants: (a) feeling engaged with the therapeutic process, (b) establishing a trusting therapeutic relationship, (c) legitimising the expression of distress associated with psoriasis and (d) guided restructuring of the meanings attached to psoriasis. The interrelation of these concepts was found to represent the processes necessary for achieving therapeutic change and the associated benefits with it. Equally, the absence of these factors or the presence of certain hindering conditions (e.g., unsuitable levels of directiveness by the therapist) could compromise the therapeutic experience of CBT and jeopardise progress.

According to the model, the process of Guided Therapeutic Growth commences the moment the patient enters the therapeutic dyad and embarks on a therapeutic journey as guided by the therapist. Firstly, the analysis suggested that patients' engagement in therapy needs to be fostered from the outset, in order to facilitate the subsequent therapeutic progression and lead to the therapeutic benefits. In particular, feelings of engagement early on in therapy were aided by exploring participants' expectations of CBT, setting realistic and specific goals, developing an understanding of the mind-skin connection and how psychological factors impact on their psoriasis, and engaging with the assigned homework. Attention should be given to situations where the patient enters therapy with negative preconceptions about homework. Those who felt engaged from the early stages of therapy considered the process as having well-defined therapeutic boundaries, which helped them experience therapy as a structured, caring and safe

place. In cases where the process of fostering feelings of engagement was unsuccessful, participants expressed feeling lost, uncertain as to what they ought to be doing in therapy and directionless, all of which influenced the subsequent processes of therapy.

Establishing the foundations of the process of Guided Therapeutic Growth for patients' feelings of engagement facilitated the formation of a trusting therapeutic relationship based on collaboration, with a therapist who did not criticise or judge them negatively, as they might have feared because of their stigmatising condition. On the contrary, this relationship was based on collaboration and understanding on behalf of the therapist and facilitated the development of feelings of trust and comfort leading the participants to believe that they are accepted by their therapists. In this context, the participants' relationship with the rest of the dermatology team further facilitated their trust and engagement with the overall therapy and was considered to often preordain, to a certain extent, participants' initial attitudes towards their relationship with the therapist.

On the other hand, when aspects of the therapeutic relationship were experienced as weak, for instance the therapist did not provide suitable levels of directiveness to the patient or feedback was absent, then the participants felt unsupported and were more likely to disengage from the therapeutic process. These were all construed as factors that could jeopardise the outcome of therapy, hinder therapeutic growth and negatively affect the therapeutic process.

The third concept explored the extent and manner in which therapists legitimised the expression of the participants' distress associated with their psoriasis. Legitimation of their feelings was

developed by an environment where patients did not worry about burdening their therapist with their distress around their skin. While this is fundamental to what talking treatments offer, it was found to markedly contrast participants' own experiences outside their therapeutic experience. For instance, when participants expressed their distress associated with psoriasis to their family, friends or even to other healthcare professionals (e.g., GPs) it was often belittled or considered as unimportant making them feel vain. Feeling legitimised to express and talk about their distress was therefore found to be a unique experience for them. This process was further accomplished by providing participants the space and the time to express their distress around inter-related factors influencing psoriasis to a therapist who did not invalidate their emotional experience, who was interested in them and acknowledged the presence of distress and what they were going through. Attention should be given to situations where the patient experiences the externalisation process of emotional release as too revealing and consequently withdraws from it.

The fourth concept described the factors impacting the process of cognitive restructuring of the meanings attached to psoriasis. This last concept included targeting thoughts in relation to a perceived sense of loss of control, which is common among individuals with psoriasis, and developing alternative and more adaptive views of their skin condition and their negative appearance schemas. This phase of the model also included a process of recalling their former or ideal selves and the life they used to live or could have lived had it not been for having psoriasis. Cognitive restructuring helped participants process the meaning of the perceived sense of loss attached to this former/ideal self and marked a decisive moment for them because it included a process of adversarial growth. Within this process, the participants challenged their negative

beliefs attached to psoriasis by acknowledging and accepting one of the central illness beliefs around psoriasis: its chronicity.

Participants who successfully went through the process of Guided Therapeutic Growth reported therapeutic gains. These included: (a) coping better with stressful situations; (b) gaining a sense of empowerment that helped them feel more in control of their lives rather than allowing their skin condition to dominate; (c) developing a self-compassionate stance that reflected taking care of themselves more and attending to their own needs; (d) the ability to disengage from negative thinking processes and substitute this thinking with a more balanced and less self-critical one; (e) feeling less anxious, less depressed and more self-confident; (f) acquiring a reflexive stance through which greater self-awareness and self-acceptance was achieved leading to a reduction in distress and alleviation of their emotional pain.

In summary, the participants underwent CBT as part of their medical care and achieved therapeutic growth via a guided process that incorporated the complex interrelation of the aforementioned four key concepts. The elements of guidance and growth were found to hold the theory together, influencing the participants' experience and the eventual outcome of the psychological management of their psoriasis.

### **Concept 1: Feeling engaged with the therapeutic process.**

This concept is intended to reflect the importance of, at the outset of the therapy, fostering feelings of engagement of the patient with psoriasis. In this study, the participant's level of engagement was influenced by the following processes: exploring patients' expectations of their CBT treatment, setting specific and realistic goals, educating them more about the mind-skin

connection, and engaging them with homework. Feeling engaged with the therapeutic process helped them become familiar with the CBT process, gain clarity regarding its structure and objectives and develop feelings of comfort. These processes helped set the foundation on which the subsequent therapeutic factors developed.

*a) Exploring patients' expectations of CBT.*

For the majority of the participants, CBT was offered either because medication had been unsuccessful and their quality of life was impaired or because it was not as effective as patients expected it to be, leading to feelings of desperation and disappointment with their clinical treatment and unhappiness about their appearance. *Emily: "My psoriasis goes crazy and, it doesn't matter what kind of treatment I took, the psoriasis didn't go away" (458-462).* This sense of disappointment and desperation drove some participants' high expectations in relation to CBT's therapeutic effectiveness in alleviating their skin-related distress. For instance, Lily had placed unrealistic expectations on her treatment outcome and described feeling shocked when discovering that her expectations of CBT could not be met because CBT did not include "fix-it" solutions.

*Lily: I thought I am gonna talk about it and then I will get off my chest and then my psoriasis is going to get better, but in the course of the treatment it was a shock to realise that I have to accept that I can't find a solution! (402-410)*

She also thought that her treatment would focus on speaking about parental figures: *"I was interested to explore that (i.e., CBT), but I was a bit sceptical..I kinda thought that they are gonna blame my mum..and it is going to be that kinda of thing." (31-41).* Her experience stresses

the importance of exploring participants' expectations at the initial stages of therapy in order to avoid later on disappointment.

Others, though, had more reasonable and realistic expectations from CBT. For example, Stephanie expected that the treatment would help her deal with her current difficulties instead of focusing on earlier/childhood life ones. She also expected to explore these difficulties in a safe environment where she could engage in a process of self-expression with her therapist's help.

*Stephanie: But we never, quite rightly, never got to things like, ehmm, the kind of issues that I guess you do in psychotherapy where there may be you know, transference or anger..we never got to that depth or level, which was appropriate, I didn't expect it or want it (201-208). It was an opportunity to come and look at the issues in a safe environment with another person (i.e., the therapist). (224-226)*

The analysis also showed that publicly available information influenced participants' expectations regarding their possible therapeutic outcome because many had sought out information on the Internet prior to commencing CBT.

*Claire: All I found out on the web before I came here was that it was sort of, about learning to reprogram your thinking a little bit..that's sort of what I gleaned from it, that it's about changing your thought processes. (67-70)*

Another participant, Lily, was influenced by TV programs and thought that her therapist would just listen to her passively and silently. She was surprised to actually experience a more active therapist than what she had expected. *Lily: "I was surprised cause you have the..when you watch*

*TV shows you see the patient laying on the couch and the doctor with the notepad and the pen just nodding and not saying anything..any suggestions.”(290-295)*

Therefore, exploring patients’ pre-existing expectations of the therapeutic outcome and explaining what CBT could actually offer them was deemed important in order to avoid misunderstandings, confusion and disappointment and help them understand the therapeutic process better. *Becky: “I think that once I got to know how it (i.e., CBT) worked and got to know that, then I felt well, comfortable I suppose..ehm..but thinking initially, I did find it hard.”(289-292)*. This process fostered engagement in therapy and supported the identification of therapeutic goals as described in the following category.

*b) Setting specific and realistic therapeutic goals.*

Apart from exploring patients’ expectations of CBT, what was determined to further assist engagement in therapy was the guided identification and establishment of specific and realistic therapeutic goals, such as engaging in processes of self-reflection in relation to psoriasis. *Becky: “I think...that was one of the goals in sessions..was to think about what I felt about it” (i.e., psoriasis) (449-451)*. Without established therapeutic goals, participants were confused as to what they ought to be doing, leading to passiveness and uncertainty.

*Claire: I think at the very beginning, when I first came, I didn’t really know what I was supposed to be doing..I felt a little bit passive, I felt like I was supposed to be doing something, because I’d kind of read this thing about, you know, reprogramming your thinking..I thought “Should I be actively trying to do these things?” (75-86)*

On the other hand, participants who had not set specific therapeutic goals and had not received sufficient guidance from the therapist towards the establishment of such goals, felt directionless and perceived the process to be unstructured. They expressed a sense of not achieving therapeutic progress and not coming to new understandings.

*Tom: I think it (i.e., CBT) wasn't very structured and I just talked about whatever I..it's like going to a meeting and talking about whatever I wanted to talk about..and I, it wasn't, ehmm, It wasn't that bad experience but I didn't feel as if it was being led anywhere..I..didn't deal with something in a different way, or identify something differently than what I'd always thought about it. (290-310)*

Furthermore, the analysis determined that setting and agreeing on goals and objectives added an element of structure to the therapeutic process, provided guidance to patients, helped them feel comfortable and enhanced engagement in therapy. It also helped them obtain clarity regarding the therapeutic process and better understand what to do and how to engage within the process. For instance, it took Martin a while to grasp the overarching structure of CBT, which he believes caused him to feel resistant, confused and lost as to what to do and how to engage in therapy and trust the process.

*Martin: For me..it took a while to understand actually what we are doing here..because if you don't understand what you are doing, it just goes over round and around in circle without knowing what you are doing..and obviously comes to the point saying "What am I doing here actually?"(230-239)..In the beginning I didn't know, I wasn't..I didn't trust it..I didn't know that it was going to be helpful to me..I didn't know actually what am I doing, I just did it because I thought maybe it could be helpful..I was resistant. (241-248)*

Revisiting the therapeutic goals within the course of the treatment was also emphasised within this category. Guided attainment to specific and realistic goals with the therapist's help was found to reduce feelings of directionlessness and facilitated a positive therapeutic experience. Stephanie talked about the therapist's key role in guiding the patient towards the therapeutic goals, thus fostering a structured therapeutic environment wherein patients had a focus.

*Stephanie: I think the main thing is to use the sessions as wisely as possible and as focused as possible therapeutically (528-531). I think, you've got to really focus on "Well, what's the work that we are doing here, what do we want to get out of it?" But it didn't.. I didn't have a focus. I didn't have a focus on the way which we worked. I think to do that, you probably have to raise the awareness of the recipient.. so, you know, I know that..okay we are refocusing, we are re-doing. (650-697)*

Additionally, not setting realistic or specific goals was described as inhibiting the therapeutic progress because it led to increased disappointment, anxiety and fear of failure. Participants, as in Claire's case had many different goals they wanted to achieve in therapy. Without having set a specific and realistic list of goals, the participants put themselves under extra pressure to achieve goals that had not been realistically assessed and agreed on from the outset.

*Claire: It was kind of weird because I had all these things that I wanted to achieve when actually what I was trying to do is to achieve less and put less pressure on myself and I felt, you know, we got to the end of the sessions and, ehm, we went through if I had done any of these things and I sort of felt short 'cause I hadn't done all of them. (338-353)*

Apart from establishing therapeutic goals that are realistic, specific and attainable, it was also deemed important that these objectives be achievable within the timeframe of the CBT therapy offered in this Psychodermatology service. Allen acknowledged the time constraints of CBT and regardless of the short-term element of it, he expressed satisfaction from engaging in a CBT process and felt hopeful about achieving progress in specific areas among the wide range of issues he was facing.

*Allen: I don't think I revolutionised, it wasn't like huge major thing because I don't think that with so many things that are with me to be sorted out that it would be fair for anyone to sort of think in just six sessions or something..but it did leave me with so, she left me with the feeling like some positive things that I could sort of take away with me about particular things, but as I said I had lots of other issues. (356-365)*

Therefore, the establishment of specific and realistic goals was deemed as being of utmost importance because it conveyed a sense of therapeutic structure and fostered feelings of engagement in the therapeutic process. Additionally, given the time-limited nature of CBT provided in this Psychodermatology service, setting such goals prevented the triggering of negative self-evaluations and development of feelings of disappointment or inadequacy of participants for not achieving their unrealistic goals.

*c) Linking the skin and the mind.*

Psychoeducating the patient and helping them understand the link between the skin and the mind was further considered from the analysis as a way of fostering participants' feelings of engagement in a structured and guided therapeutic experience. Recognising the mind-skin

connection helped participants understand better the triggers for their psoriasis flare-ups and the two-way relationship between psoriasis and stress from their daily lives. This was achieved by exploring stressors that were related to the onset, the impact and the progression of the condition.

*Lily: So we were exploring whether it was the shock of that to the system that brought it (i.e., psoriasis) out, it's been a difficult few years and so it was making the connection between the "Ok well, maybe there is a link, actually between these events that had happened in my life and what's happening with my skin". Whereas before, I haven't really thought about it like that..it was like what have I eaten. (91-102)*

The participants described that with their therapist's help and guidance they developed a continuous understanding of what exacerbates their psoriasis symptoms, they were better prepared for a flare-up and realised that they can do something about it (i.e., ask for help).

*Becky: With a bit of help..dealing with it (i.e., psoriasis) and also know the triggers as to what might make it worse, and trying to find a way through that..When things were crowding in on you and..and I immediately felt this was going to affect my skin, I knew to put my hand up and ask for help. (643-652)*

The effects of guided psychoeducation were found to have a lasting positive effect because participants could continue identifying potential triggers for a flare up even long after leaving therapy. Participants described how they benefited from gaining information about the mind-skin link and how this made them feel more empowered and in control—two significant elements for individuals with psoriasis who usually feel powerless due to the uncontrollability of their skin condition.

*Claire: I was feeling helpless..and now I don't feel like that at all, I feel like I've got a good understanding of what triggers my psoriasis and what to do to help me have the control! (645-648) . . . I think psoriasis just, was sort of, I guess a physical manifestation of my state of mind at that time (682-684). It's a vicious circle and you are stressed about your psoriasis, which makes the psoriasis worse. (707-713)*

*d) Patient's attitudes towards homework.*

Feeling engaged with the therapeutic process was further fostered by the more technical element of CBT, the homework. Homework, which is one of the key features of CBT, was described by the participants as any written task (i.e., thought diaries) and/or reading material that clients had to work on and subsequently review with their therapist. Patients' attitudes towards the assignment and completion of homework tasks varied, with some of them finding it helpful and engaging, while others describing it as not suiting their needs and as not facilitating the therapeutic process.

Among participants who had a positive experience engaging with homework, one aspect that was described as particularly beneficial was the therapist's guidance towards tasks that were targeted to the patient's specific needs. Ensuring that assignments were relevant and tailored helped the participants better understand their particular situation, and engaged them further in the process of completing and reflecting on the assigned homework.

*Lily: So, what I found really helpful was not just talking about things and throwing out ideas but also I was given some reading material to read about what it actually means..I was being directed to certain reading which I found quite helpful, and sometimes one*

*would resonate and the selections that were made for me and various chapters I found very interesting (174-189)*

Through the process of engaging with relevant homework, these participants recognised their own personality traits and slowly started engaging in cognitive processes, such as alternative thinking. Claire elaborated on this aspect, explaining how a tailored homework assignment complemented the cognitive process of self-reflection and self-awareness.

*Claire: It was things like, with homework, we got into discussion about me being a perfectionist (136-138), but you know just kind of, you read them, and it says “Do you see any of your tendencies in these?” and I was like, “Yeah that’s me, I do that, I do that”..When I was reading things, sometimes I was like, it was just a bit of self-awareness I guess, getting a bit of that self-awareness and, ehmm just, you know, starting to think about like what I could do a bit differently (176–180). . . Giving me the opportunity to go away from here with things like that, the case studies, and, you know, to go and have just like a reflection time on my own. (534–536)*

Additionally, the analysis found that homework helped participants refresh their memory of the therapeutic material discussed in session and acted as a supportive link between the therapeutic sessions.

*Becky: Oh, it was good, for me it was good because it, just, you know, when you are sitting in the room with someone and they, you can't remember everything you were told, I was glad to have something to look at or to read after to sort of think about for the next time I came (223-227).*

Their positive attitude towards homework was reflected in participants' active application of the CBT internalised learning and in the therapeutic insights that have been gained. This was found to enhance engagement in therapy, fostered a self-reflective stance and indicated positive treatment outcomes. Claire illustrated the link between feeling engaged, adhering to homework and feeling motivated to actively get involved in this process rather than sitting back and passively complaining about psoriasis.

*Claire: [You need] to commit to trying to, ehmm..use it (i.e., homework), you know, cause I think it could be quite easy to just sit in this room and not really apply anything, you know, if you have to, if someone goes to do this (i.e., CBT), they have to actively want to learn from the experience and do something about it. If you are just gonna sit in a room for 12 weeks and you want to complain about your psoriasis, CBT probably wouldn't be the right thing. For me CBT was for you to actively try to do something, you know. I feel that I would say to people grab it and do something with it, don't just sit there and you know, do your hour, walk out of the room and forget about it. (777-797)*

On the other end of the spectrum, there were participants who did not adhere to homework assignments. In this case, patients carried negative preconceived notions about homework and associated it with a negative view of self, partly resulting from previous negative experiences with it. Homework was contrasted with the process of verbal emotional release and self-expression during sessions, which was described as much more beneficial. Elaborating on this point, Martin described homework as not suiting his needs and associated it with unpleasant responsibilities from his school past.

*Martin: I found it all very difficult, never liked homework all my life, and I was very bad at that. But for me, basically just sitting and doing it on a paper, I wasn't after that..maybe for some patients it's easier to write it down and just try to memorise that or remember that, for me it was the discussion more important. (278–290)*

Consequently, the analysis deemed that the therapeutic progress was likely being hindered and the therapeutic gains limited in part by the patient's lack of engagement with homework and its associated self-reflective practices between sessions. Notably, participants such as Martin who did not fully engage with a core CBT element such as homework, reported only a small improvement of their symptoms, a temporary relief of their distress, and therapeutic effects that were not lasting. Martin: *“That (i.e., verbal self-expression) was an immediate relief for me..like I said because of the situation I was in..I had a lot of pressure on me and that pressure came back after few hours..but the immediate effect it was a relief..”(328-332)*. The relief was temporary and the negative and self-critical beliefs the patient was already holding were more resistant to change.

Summarising the findings of this concept, it was surmised that the absence of a well-explained and clearly defined therapeutic process that takes the form of exploring expectations of CBT, setting realistic and specific therapeutic goals, engaging with homework and gaining greater understanding of the mind-skin link might diminish engagement in therapy, hinder the patients' experience of therapy and the subsequent therapeutic progress. On the other hand, engaging the patient with the therapeutic process was thought to help them understand what CBT is, establish

clear therapeutic boundaries, manage patient's expectations and as a result, reduce the risk of disengagement.

### **Concept 2: Establishing a trusting therapeutic relationship.**

Another important factor emphasised by the participants as contributing to the outcome of CBT was the establishment of an idiosyncratic therapeutic relationship with the therapist. Participants suggested that such an approach helped them feel special and important, attended to and genuinely cared for as the treatment was personalised to each patient's specific issues and accommodated their needs. This trusting relationship disconfirmed previous negative treatment experiences of healthcare professionals who treated them anonymously en masse making them feel unimportant or as just another patient from the treatment list. For example, Claire and Becky commented positively on their relationship with their therapists explaining its significance and how unique they felt it was:

*Claire: Even now, when I see her (i.e., therapist), when I am coming for my medical appointments she would ask: "Claire how are you?" you know, "How's work? How was the holiday?" you know, I feel like I am not, I wasn't just another patient that, you know, just like "the nine o'clock is here". I felt like she had a genuine interest in trying to help me and support me and make me feel better..that sort of thing. (553-565)*

*Becky: I probably felt it quite an intense experience, only because, ehhm, I'm not used to people (i.e., therapist) taking that much trouble on me. She was here till, you know, she gave her time and helped me and that was, you know, unique. (242-250)*

Factors that fostered the development of such trusting and unique relationship were feelings of care and acceptance of the patient by the therapist who was perceived as understanding,

collaborative, non-judgemental and a good listener. For example, Stephanie said: *“I found the therapist to be very sensitive, very empathetic, and a very lovely person, very communicative, easy to be with, so many, many lovely qualities.”* (325–329). The relationship was also strengthened by the therapist providing suitable levels of directiveness to the patients by being empathically attuned to client’s experiences in each moment and responding appropriately. Lastly, the establishment of a trusting relationship was further assisted by the feedback provided by the therapist on the participants’ progress and by the nature of the already established relationship with the clinical team.

These four factors constitute the four categories of this concept:

*a) A non-judgemental relationship based on collaboration.*

When dealing with the sensitive and emotive topic of disfigurement, power issues within the relationship can be especially pertinent because they could hinder engagement and therapeutic progress. The participants of this study highlighted the feelings of parity versus the therapist’s absence of an authoritarian disposition as enabling feelings of mutuality and collaboration to develop. They described this process as working collaboratively with a therapist who was providing guidance without presuming expertise. Emily commented positively on how her collaborative bond with her therapist led to an understanding of her difficulties and a joint discovery of awareness.

*Emily: So, you know, if I was thinking about something, I would come back to the session the following time and ask questions my therapist and then we would take it from there. So I felt really, yeah, I think it was really 50-50..We discovered awareness, definitely working together..like a collaboration. (293–302)*

Allen reinforced this collaborative point and the absence of therapist's authoritarian expertise, and he additionally suggested that one way to convey parity was by inviting patients' feedback regarding the therapeutic experience and the therapist's approach. Such invitation further enhanced the therapeutic relationship, it reduced any pressure related to the therapeutic experience and gave them a sense of empowerment.

*Allen: I think one of the things I liked, one of the first things she said, you know: "If I am saying or if I am acting in a way you don't like and things, you are entitled to say, to talk to me about it", which I liked, that's good because it makes things mutual rather than "I am in charge" and "I am here to help you" and, you know, start taking a higher ground, which I think some therapists did in the past, which for me is not good because it was adding that sort of pressure. (322–330)*

Given that society places a major role on appearance, and individuals with psoriasis often fear that others will evaluate them negatively because of their appearance, the participants of this study commented positively on the therapist's non-judgemental approach that was also supporting and understanding. In particular, a non-judgemental therapeutic approach was found to play a significant role in establishing trust, encouraging participation in the therapeutic process, fostering self-expression even when that process was emotionally upsetting, and facilitating the participants' therapeutic growth.

*Emily: Even then (i.e., when I was crying a lot), I was quite comfortable showing my vulnerabilities. So, in terms of that my therapist was great(86–92). . .But I never felt like "Oh maybe I shouldn't have said that" or "I'm embarrassed to say that" or, "I felt embarrassed because [my therapist] might judge me or anything like that", you know,*

*very, very, comfortable (245–249). I think [my therapist] is non-judgmental . . . So, ehmm, for the time when I was coming here she was, in a way, you know, a pillar for me. (322–329)*

Claire also described the value of being in a non-judgemental therapeutic relationship and feeling accepted, which was unlike her previous stigmatising experiences: *“I found her, she was very calming and, you know, accepting” (529–531) . . . “I felt she was very understanding of the things I was talking about and I felt, you know, she was very supportive” (553–555)*. Therefore, providing a caring and understanding therapeutic relationship wherein the patient would not feel judged, was considered unique for them because it did not reinforce previous negative self-perceptions, and did not perpetuate past experiences of stigmatisation, but instead it fostered an environment of acceptance.

The analysis deemed that this collaborative and non-judgemental way of interacting with the therapist fostered feelings of trust and worked as a therapeutic base for the following concept of emotional release via self-expression to occur. It further solidified feelings of acceptance and understanding and improved the CBT experience of patients with psoriasis.

*Allen: I think it’s important to, you know, to have some kind of rapport with someone if, if you don’t reach that point..and in particular when it comes to talking about very personal stuff, that’s not easy (62–64). . . So, the important thing for me was setting a rapport with the therapist and so I guess it was achieving some kind of trust where you felt that you could share your personal sort of things and the things that were causing upset in your life. (98-105)*

*b) Maintaining suitable levels of directiveness.*

Participants talked about the importance of working with a therapist who could remain attuned to their moment-to-moment emotional and cognitive state and be empathically directive. In this study, being empathically directive refers to an interaction style wherein the therapist became attuned to the nature and extent of the client's distress, understood their therapeutic needs at each moment, and communicated with the appropriate levels of directiveness while remaining sympathetic. Along such a spectrum of directiveness, the analysis showed that on one end an insufficiently directive therapist was someone who was warm and understanding yet did not provide the recommendations or suggestions in the therapeutic process as assertively as the clients expected. On the other end, an overly directive therapist was someone who was experienced as being too confrontational and over-leading, beyond simply being suggestive. Unsuitable levels of directiveness were found to hinder engagement and challenge the collaborative nature of the relationship because the participants felt either led, overly challenged and criticised or, on the other end, directionless, unchallenged and not achieving change.

For example, Martin shared his experience of a therapist who was coming across as insufficiently directive and said how much he would benefit from being pushed more to face his situation. Furthermore, he expressed the need for more active involvement and suggestions about what he could do in order to deal with his difficulties and achieve therapeutic change.

*Martin: I wanted her (i.e., my therapist) to just get involved in that (i.e., in what I was saying) (399–402) . . . Maybe sometimes I thought she was very careful with me and she tried to be..not very critical. I was critical of myself, that was the point why I was here. I*

*wanted to be changed by somebody, basically take me and shake me and tell me “Look, have a look at what you are doing, find a way to deal with the problem.” (417-430)*

Equally ineffective were occasions when the therapist was perceived as being beyond suggestive and was overly-directive. The analysis deemed that this approach was perceived as judgemental and critical, and evoked adverse feelings from these participants who had typically experienced stigma, judgement and rejection in their daily lives due to their skin condition. Being overly directive could jeopardise engagement in therapy and trigger feelings of being criticised. As Lily remarked:

*Sometimes she made me overshare. I felt she was quite critical, which was sometimes welcomed but other times I was surprised. When saying “How do you do this? Why do you do that?”, that’s fine. But “Maybe you should [emphasis added] be doing this, maybe you should [emphasis added] be doing that” suggestions..But then it is a matter of a person. (276–289)*

Stephanie recognised the importance of the therapist being sympathetic and reaching out to the patient, however she said that this needs to be balanced with therapeutic rigour. She suggested that when the therapist is not empathically attuned to and understanding of the nuances, experiences and subtle behaviours of the client, and errs in either direction, then the patient’s progress and therapeutic change are jeopardised.

*Stephanie: If you are doing cognitive work anyway, I think it is important that the therapist shows sympathy, empathy, that’s got to go with it, but it’s quite hard to keep that balance, isn’t it, of being sympathetic, empathetic, but therapeutically, you know,*

*rigorous..So, if there's a tad too much empathy/sympathy that can take up time that needs to go to the therapeutic level at which you are working. I think that any therapist, any doctor has got to balance the sympathy and empathetic component that goes into reaching out to that person and being in communication with them, but balance it with being therapeutically, sound and, you know, adding as much value as possible by effective change or whatever the outcome needs to be..Because, I think some therapists are too far one way or another. (360–422)*

In cases where the therapist was attuned to the patient's moment-to-moment frame of reference and maintained suitable levels of directiveness, this enabled further engagement in therapy, feelings of comfort and understanding. For example, Emily described how her therapist was appropriately challenging her while remaining sympathetic. She described her therapist as someone who understood what she was going through, reflected on what was discussed, questioned and gently confronted her without making her feel criticised. Becky too described her therapist as being empathically directive, thus making her feel comfortable and understood.

*Emily: When I was quite distressed, she was quite sympathetic. Obviously, she was challenging me, you know, to..to..if I was saying something negative and she would say 'Why?' or whatever, so she was assertive but yet very sympathetic. So, it was really, really pleasant at least, you know, I didn't feel uncomfortable at all.. If not, I actually, at that time, I was looking forward to coming here because I really, I could see the benefit of it. (312-329)*

*Becky: Actually, I would definitely say the balance was right. She wasn't over-involved or very empathetic or whatever...And yes, I do feel that..that she understood what I was about and I would say she, she played it right. (400-405)*

*c) Receiving feedback.*

Under this category, participants talked about the importance of receiving feedback from their therapist both on the therapeutic measurements they completed throughout the treatment and also on their progress in therapy. It was important for the participants to know the meaning of their scores on the questionnaires—for example, the HADS—as a way of understanding their progress in therapy, and feeling more actively involved in their treatment. On the other hand, not receiving feedback appeared to influence negatively the treatment experience and diminish engagement in a trusting therapeutic environment because patients did not feel supported or part of the process. For example, the absence of feedback in Tom's case raised questions and possibly created doubts regarding his perceived sense of collaboration in therapy and his experience of treatment.

*Tom: I am being measured on how I talk about my condition, I've been filling all these forms for regular check-ups and my scores were usually..quite high or whatever and then I asked what it was that about and it was about anxiety and depression. So then I asked what were my scores and I was just told quite casually that "You are moderately anxious and moderately depressed". That was quite interesting how that was not managed, that information, and that was, problematic, I suppose. (486-503)*

The benefits of receiving feedback were associated with a smoother ending of the therapeutic sessions. Claire, for instance, mentioned that she would have welcomed feedback about her

progress as a way to wrap up therapy. The absence of such feedback made her feel as if something was missing from the process and the ending was described as abrupt.

*Claire: There wasn't a huge amount of feedback in terms of the session, I think the CBT course kind of ended, and that was it. Like, I just stopped coming and, there wasn't really anything more, there was never really any, I don't know..feedback..feedback from my therapist maybe that, during the sessions..feedback like "Yes, you seem, like you are doing a lot better". The whole thing just kind of ended, just something to kind of wrap it up a little bit. Because it felt a little open-ended..one minute you are coming every week and telling all your big things to people and then it's like "Okay well, right, that was the last session."*  
(367-412)

*d) Existing relationship with the dermatology team.*

Finally, within this concept, participants placed great importance on the already formed relationship with the other clinicians who had been involved in their treatment, such as their clinical nurses and dermatologists. All participants described their physician-patient relationship as positive, which increased feelings of hope that have been lost due to their distress of their situation. It also made them feel part of a team and of a clinical system that was in place to support and understand them. Additionally, it was another factor strengthening feelings of collaboration and trust.

*Martin: It was very difficult time for me and I appreciate my therapist's and my dermatologist's help at that time..it was helpful to me because that situation I was in, it was very difficult for me and I found like, I was alone fighting the whole world and*

*coming to the hospital and seeing the clinical team, I thought that was very helpful to me. (180-186)*

*Lily: So, I did a bit of thinking about it (i.e., receiving CBT) and then when I was in the system I thought, "why not?" (17-18)*

*Becky: My dermatologist is fantastic and she knows what to ask and to see whether I might need a bit of help and this definitely made a difference. (203-207)*

The nature of this positive and trusting relationship worked as a springboard to embark on the CBT journey that was mutually decided by both the dermatologist and the patient. *Martin: "I was under the treatment of my dermatologist and we came to the conclusion 'why not try it. It could be a good treatment'..and that was the beginning of the whole thing." (33-35).* As such, the analysis indicated that an already established positive relationship with the clinical team had enabled not only the participants' engagement with the CBT process but also the development of a positive and trusting relationship with the CBT therapist.

As a way of explaining the significance of a pre-existing positive relationship with their clinicians, some participants compared their current experience to previous relationships with clinicians who did not have an awareness of the psoriasis's psychological impact on the individual. They explained that they felt safe and understood when their emotional difficulties resulting from psoriasis were acknowledged and addressed. Claire's experience, that is not atypical among individuals with psoriasis, is related to health care professionals' lack of empathy and understanding of the psychological difficulties resulting from psoriasis, evoking feelings of disappointment towards the medical system and ineffective treatment avenues. Claire

emphasised the importance of a holistic approach, which was provided to her in this particular Psychodermatology department.

*Claire: I think it's really misunderstood the effects that psoriasis could have on your personality and your mental health and your well-being..it's not just a skin disease.. if I hadn't done it (i.e., CBT), I might not be where I am today with everything because I would be still rubbing cream on myself, I don't think that I would have, gained this awareness!...That's (i.e., psychological impact of psoriasis) almost unheard of in health care and in general..when I went to the GP they told me to just get a tube of cream, you know. I think there should be a huge amount of more awareness around these therapies or an essential part of treating the disease. (807-828)*

Participants' positive experience from their treatment both by the clinical team and by their CBT therapist, regardless of the therapy's perceived effectiveness in reducing their presenting symptoms, has motivated them to get involved in this research because they felt greatly helped and appreciative of the holistic and tailored support they had received. Their willingness to participate also reflects the need to increase awareness of the psychological impact psoriasis has on someone's life and inform the public that effective treatment approaches do exist. *Claire: "I found CBT a very good experience and I would like to be very supportive of anything that we could do to offer this therapy to more people."*(805-807). Additionally, Lily reported:

*Lily: I think that the whole, everything that they offer in this dermatology programme is super very helpful and everyone is very sympathetic. I think I wanted to be a help, to be part of this survey as everyone has been really trying to help me. (651-654)*

### **Concept 3: Legitimising the expression of the distress associated with psoriasis.**

Establishing a trusting, collaborative and non-judgemental therapeutic relationship was deemed to facilitate the process of patient's self-expression about the highly distressing symptoms of psoriasis. Within such a therapeutic relationship, the participants were more comfortable expressing their emotional pain to a therapist who was giving them the space and the encouragement to do so. Participants contrasted this experience with the process of expressing their distress to family members or others, in which case their pain was often trivialised, dismissed as vanity or made them feel they were being a burden. The analysis of the results found that therapists could legitimise the participants' expression of their emotional distress by enabling a process of a non-burdening emotional release, not dismissing patients' appearance-related concerns, and exploring the emotionally upsetting inter-related factors that were influencing the symptoms of psoriasis.

#### *a) Providing the space and the time for non-burdening emotional release.*

Under this category, the participants spoke about one of the most fundamental aspects of talking therapies, that is the emotional release through verbal expression. Confirming the beneficial aspect of the verbal emotional release, Claire said: *"I can look at it retrospectively and see that it definitely made a huge difference and it made a huge difference talking at the time"* (396–398). Emily supported this view by saying: *"Talking for me was a very big revelation and it helped me definitely, you know, analysing other things, moving forward."* (213–216)

In this context, a factor that emerged from the analysis as being particularly important was patients' ability to externalise their emotional pain in a safe and non-burdening environment particular, without trying to protect others or worry about their family's feelings. *Claire: "I*

*didn't want to tell my mum and dad I was upset because they just worry about me and I didn't want them to worry.”(292-295)*

Participants described this process as unique and empowering. It facilitated engagement in therapy and promoted further self-exploration and a sense of relief. Participants released their suppressed emotions with the facilitation of an encouraging therapist who projected feelings of safety and tolerance without making the participants feel like a burden. *Emily: “My therapist was encouraging me to, you know, express it or whatever the emotion was at that time, to express it..It was difficult because it was painful..But having said that I still felt that it was in a safe environment” (350-357).* Similarly for Allen: *“It was more the talking things through from week to week. I was looking quite forward to it because it is sort of.. the sooner to get it out the better to deal with it.” (469–473)*

Notwithstanding the many benefits of verbal emotional release, one of which was the non-burdening experience, the analysis also identified the possibility for this process to adversely affect the outcome of CBT and hinder therapeutic growth. This can occur in cases where the patient experiences the externalisation process of emotional release as too revealing, or where the patient believes they have over-shared. This can create pressure on the patient, it can lead to feelings of discomfort, and result in the patient subsequently withdrawing from the process of self-expression and withholding the distress externalisation.

*Lily: I was often finding that I was feeling very raw afterwards 'cause I was realising that I was being quite revealing (123–125). I had a bit of mixed feelings, in terms of the process (129–130). . .I ended up feeling quite negative after the sessions (221–223). . .*

*Sometimes there was a bit of negative issues and I didn't, yeah, it didn't make me feel good, it didn't help, when I came back for the next session I was trying not to share so much. (232–239)*

However, over time and as therapy progressed and the relationship became more established, participants familiarised themselves with therapeutic process, felt increasingly comfortable with an understanding therapist who legitimised their distress and they engaged better with the process of self-expressing without avoiding painful aspects. They progressed from initially feeling exposed to gradually feeling relieved and benefiting from self-expression. This implied an iterative, interactive and to an extent sequential process encompassing feeling engaged in therapy, establishing a trusting therapeutic relationship, and ultimately engaging in a self-expressive process.

*Becky: I think I found it, ehm, quite daunting at first because I felt I had to talk. So, I felt there was a slight of pressure there I suppose, ehm, and was quite difficult at first. I would come here and I'd have to be saying something. But once I sort of, once I got into it, I think, I then was able to let go more or go with it. (278-283)*

Becky continued saying:

*I was thinking, you know, I got to turn up, tomorrow, and I've got to think what am gonna say, but I think after a while that changed..I know it certainly changed in the long term because I now feel much more able to talk to when I need to. But certainly at the beginning it was difficult. (293-300)*

Lily also stated:

*'cause even though I felt battered at the end and very emotional after each session, it was also at the same time a release and a relief (325–327). I now feel much more able to talk to when I need to..talking is therapeutic. (443–457)*

*b) Not dismissing the patient's appearance-related concerns.*

Another process that enhanced participants' feelings of legitimisation of self-expression was the one of not having their concerns in relation to their appearance dismissed or invalidated. Participants of this study commented on the substantial difference between expressing their appearance-related concerns outside the therapeutic setting—for example, to their friends—versus to their therapist. They explained that, outside therapy, their concerns were often belittled, dismissed or perceived as a sign of vanity. Within therapy, though, their experience was different. Their accepting therapist acknowledged their distress and their concerns about the impact of psoriasis and did not make them feel rejected or as if they were moaning. This meaningful to them experience fostered a sense of legitimisation of the expression of their distress and helped them feel understood, listened to and supported.

*Claire: With something like psoriasis it's very hard to explain to people what an effect it's having on you. They just say "Oh it's a bit of itchy skin", you know, it is very hard to explain to people, because you feel like you are being vain (91-96). I didn't really tell anyone that it was affecting me, like I said, because you feel vain and it feels trivial compared to people who have more serious diseases, so I was being able to be upset here (i.e., in therapy)(289-295). It's a very hard thing to say to your friends, even your close friends that actually you are really upset because you are not able to wear any of the*

*clothes in your wardrobe for the last few months, it just sounds so pathetic (296-300).. You don't want to just sit moaning to your friends about it because, you know, okay they might be a bit sympathetic but they don't really understand so it was good being able to actually say these things and be upset about them here, definitely (307-312)..People just see it as a skin disease, they don't see it as a mental health issue. (314-317)*

This category was also related to a process of having the permission and the time to moan about psoriasis without feeling guilty or as if they have done something wrong. From their accounts, it was evident that there is a great lack of understanding from patients' immediate environment about the psychological impact of psoriasis that consequently led to them feeling dismissed and their emotional pain trivialised and belittled.

*Lily: They (i.e., family/friends) think..it's just.. "There is nothing wrong with me..it's just superficial, this one that has cancer and this one has this and this one..it's not really a big deal in the grand scheme of things"..So to moan about it, it felt wrong. (48-56)*

*Allen: I think it's just, you are allowed, you are given some time to just talk about yourself without feeling, I don't know, ehmm, vain or selfish about things..I think the way that we worked it was good, it was my, my time to put things out. (244-250)*

*Claire: "It's only a bit of flaky skin", you know, "Other people have cancer! Okay?"..People don't treat it as something serious because it's not life threatening, and it's not, you know, it's not, it's not going to kill you. (115-118)*

The analysis determined that participants' distress was effectively acknowledged and not dismissed by a therapist who related the participants' experiences to other people with psoriasis

and reassured patients that their distress was not uncommon or misplaced. This approach led to feelings of relief, distress normalisation and helped maintain a stance of disclosure without feeling that their experience is belittled or unimportant. Lily said: *“In the beginning, I was very emotional, I mean I was crying, bursting to tears and I wasn’t expecting that, but my therapist said that that happens a lot”* (119-121). Claire also expressed a similar view:

*Claire: In the beginning it was sort of reassuring I guess, and comforting that, you know, what I was telling my therapist was seemingly fairly common among people who had psoriasis..So in the beginning it was just having somebody who I could kind of..be upset with because you are supposed to be sort of brave in front of everyone, aren’t you, you’re not supposed to sort of moan. (111-115)*

*c) Exploring psychological inter-related factors that influence psoriasis.*

The process of having the participants’ expression of distress legitimised was further aided by not constraining therapy to the explicit topic of psoriasis and its impact on their lives. The analysis found that the participants benefited from being given the opportunity, with the therapist’s guidance and within the framework of CBT, to and express their distress resulting from explore other aspects of their life that were potential stressors and could therefore be exacerbating the symptoms of psoriasis. This category was found to put into practice the previously mentioned psychoeducation, whereby the mind-skin link was explained to the patient at a theoretical level. Participants thus felt that therapy considered not just the psoriasis but also the life of the person behind the condition. This expression of interrelated psychosocial concerns helped them become more self-aware and realise that psoriasis is not separate and unrelated to

other life-stressors but it is interlinked with different aspects of their life and it impacts and also gets impacted by them.

*Stephanie: It was a stressful time because I had surgery in 2008..And, there were things happening with the children, ehmm, the pressure was building up and the stress was building up (43-49)..Interviewer: So it seems like when you had your treatment you didn't just focus on psoriasis? Stephanie: Yes, yes that's true. I think stuff that, I guess we both felt might be feeding the anxiety and the psoriasis [stuff] that might be behind the psoriasis. (592-602)*

*Allen: When I was having the sessions, it wasn't just about the psoriasis, it was about the whole, you know, I mean I spoke about these other things that were going on..so I think you can generalise, it doesn't have to be specially about the psoriasis. (192-209)*

#### **Concept 4: Guided cognitive restructuring of meanings attached to psoriasis.**

Within this concept, participants spoke about one of the basic targets of CBT, the cognitions. In particular, they talked about becoming aware of their distressing thoughts and modifying them. They emphasised the process of being guided by their therapist to engage in cognitive disputation of their negative views of self and of psoriasis and to develop alternative and less negative ones. This was achieved by targeting cognitions related to a perceived sense of loss of control, modifying maladaptive appearance-related schemas, processing the meaning of the perceived loss of former or ideal self and challenging the negative meanings attached to psoriasis, which led to adversarial growth. The outcome of this process was the development of more realistic, compassionate and accepting views of self. The restructuring of cognitive representations of illness and the development of “healthier” beliefs were found to play a significant part in this concept that facilitated therapeutic growth. For example, Steven positively

commented on the impact of CBT on viewing his situation more realistically and his sense of view more positively. Steven: *“I have now realised that I am not a complete failure”* (707-708) and *“It’s (i.e., psoriasis) not going to kill me”* (407-408). This process of cognitive restructuring was found to be an empowering experience for the participants and it appeared to comprise the following four interlinked categories.

*a) Targeting thoughts related to a perceived loss of control.*

Several participants’ of this study expressed a perceived loss of control over their ability to cope with one of the prominent factors that characterises psoriasis; namely the unpredictability of the condition and its symptoms. For example, for some participants the psoriasis initially appeared only as a patch and then suddenly expanded to different parts of their body, making them believe that the condition grows uncontrollably and it could potentially cover their entire body. This was thought to act as a stressor and maintained worry because patients did not have any control of the progression of psoriasis. Becky: *“It came out of the blue, I’ve never had anything wrong with my skin in my entire life. Then six years ago, it just hit me with a vengeance.”*(482-484). Such experiences were found to enhance the severity of the perceived loss of control and evoked feelings of helplessness, desperation and fear. Claire’s experience with the unpredictable nature of psoriasis and the associated perceived loss of control in coping was also devastating for her: *“It was suddenly one day, it was just a little bit on my elbows and the next minute it was in my hair, all over my body and I just couldn’t see a light at the end of the tunnel.”*(35-38)

Steven's negative thoughts of perceived loss of control were associated with a fear that his psoriasis would spread unpredictably to visible parts of his body, such as his face. For him, having psoriasis on a visible part would be catastrophic.

*Steven: I was playing out the scenario that the psoriasis would grow all over my body and God forbid I would get it in my face, and, you know, imagined, the imaginative nightmare scenario of having it started here (pointing at face)..that was a genuine fear and, you know, I could not get rid of that even thinking logically. (388-401)*

However, through targeting his distressing thoughts and regaining a sense of control, Steven managed to reduce his fear, he felt more empowered and more in control of his life.

*Interviewer: So, do you believe that maybe CBT has helped at all with these imaginative fears? Steven: Oh yes, it has..yes it has..It has because, I have become aware that: (a) it's not going to kill me, (b) I am at an age and I'm wise enough, that it is not, and I'm saying that now I would not have said that say four months ago, it is not going to have a decisive effect on my life. (388-412)*

Consequently, the study found that one of the factors contributing to a successful outcome of the participants' CBT experience was the extent to which participants were able to address and target such distressing thoughts of a perceived loss of control. This could be accomplished by believing in their ability to cope with situations that are within their control. For example, having a plan for dealing with psoriasis flare-ups if and when they occur.

*Becky: I can't control certain things that happen in life, necessarily, but knowing that if it (i.e., psoriasis) was potentially going to flare up, I knew that I could come here and get help. And that is very reassuring and it did help, it has helped. (511-519)*

Typical of an individual with psoriasis who cannot predict the progression of the skin condition and they feel they are losing control, Claire described how desperate she was feeling because she had lost control of everything. However, through receiving CBT, she managed to target her distressing thoughts and regained a sense of control by believing more in her ability to cope in an adaptive way. She said she was able to develop a toolkit of ways of coping. This helped her feel reassured and empowered.

*Claire: I know what to do..and if this is as bad as it is then I'm not bothered by that so I feel like, I just feel like the whole process with psoriasis was that I was losing control of everything, I felt like there was nothing I could do to fix these problems and now I feel like I've got a toolkit of things I can do..I know I need to calm down..And also now I feel I have more control over it. (623-637)*

*b) Modifying maladaptive appearance-related schemas.*

Participants of this study made reference to views of self in relation to their physical appearance and described how their cognitions were impacted by psoriasis. During therapy, the participants were guided to explore and target these cognitions and develop less rigid ones. For the participants of this study their appearance-related schemas were related to having a perfect appearance that would reflect a perfect self. Interestingly, their accounts showed that these schemas are linked to a general view of self and their sense of worth. Modifying their rigid views

of appearance and self, helped them develop alternative perspectives and reduce the associated critical thinking in relation to an imperfect view of self. As a result, they felt less stressed and better able to cope.

In the case of Claire, her schemas had been largely placed on having a perfect appearance which in combination with her perfectionist cognitions, it was driving her behaviour and she was putting pressure to continually improve and push on to the next level in all aspects of her life. The process of cognitive restructuring helped her become less critical and less demanding of herself and viewed herself more positively.

*Claire: We got into discussion about me being a perfectionist and setting very high standards for myself and never being very content with where I am and always, trying to push to the next level...And then we started getting into more like just question like why I put so much pressure on myself and what I could do to alleviate some of that pressure on myself, you know, just being, it's okay to just, like be. You don't have to constantly be, you know, like trying to get to the next level in your job or get the bigger house or you know have the perfect boyfriend or make the perfect dinner or whatever it is, so I just kind of got into thinking about like. Slowly, well I just started to be less, ehmm, critical I guess of myself, you know, if I didn't get something done, it wasn't the end of the world, sort of thing. It's a very, conscious thing to do that. (137-162)*

The study determined that the process of modifying their negative views of their selves as formed by their appearance schemas was aided by developing an ability to think realistically. This process was found to foster a compassionate view of self because participants were more appreciative of other aspects of themselves and not just focusing on their appearance.

*Steven: I've always considered myself so unattractive, ugly because I said, "Oh my God, If that woman, if she saw me the way I see myself in the mirror, in the morning she would run away". That is something that is in here (pointing at his head) and I'm working hard to try and modify that. Now, I would think logically with my analytical mind that that particular person would already know me and she would perhaps appreciate those elements which are appreciable, and then to see a couple of patches here or around the belt in the back doesn't matter. Now this is my intelligent mind, my logical mind [speaking]. (195-215)*

Stephanie also highlighted the importance of thinking realistically without abiding to her negative schemas. She thus managed to see things differently, more positively without jumping to catastrophic conclusions.

*Stephanie: I think that was helpful to see things from a different perspective and make the effort to take up a different position (249–275). To start thinking "well is this a good thing or a bad thing?" Maybe, before I would say, "Oh it's definitely a bad thing". And now..I'm a little bit more inclined to think first, "Well, is it a good thing? Maybe." (572–577)*

By modifying their appearance schemas that were also related to a general view of self and considering alternatives, the participants of this study reported that they managed to adopt a more positive outlook in life by avoiding their usual negative automatic responses. This helped them become less distressed and alleviate their emotional pain. They gained a sense of empowerment and motivation to continue achieving change and felt more positive about themselves. *Claire: “When I felt myself doing that (i.e., having perfect expectations of herself), I would say: ‘Well, it can wait till next week..Doesn’t have to happen today’”(155-157).* Emily also said:

*You know, you sort of, think and then you, you decide, you know, that maybe you shouldn’t do that, and you should consider other things, which are really positive things (111–115). I am actually able to turn it (i.e., negative) around but it was the therapy that helped me with that (133–160)..It really helped me that frame of mind to really be positive. (519–520)*

*c) Addressing the perceived loss of former/ideal self.*

The chronicity of developing psoriasis varied amongst the participants. Some of them had psoriasis since a very young age and they have created in their minds an ideal image of themselves living life without having psoriasis. This ideal self was experienced as a loss and participants were given the opportunity to address their cognitions about this ideal life and its perceived sense of loss.

*Martin: I thought I could be a lot better, my life would be a lot easier and directly because of psoriasis I didn’t have this chance, it was holding me back (580-583). I think I*

*could have done a lot which I can't do, and I couldn't do because of my psoriasis..(544-546).. So for me, it is an annoying factor in my life. (553-554)*

Others had developed psoriasis later in life. Similarly, these participants experienced this change as a process of bereavement. This change included the loss of a carefree self in which the individual was not self-conscious with respect to their appearance. Some participants even felt as if they had to stop living their lives the way they used to by changing behaviours related to how they dressed and adopting a more restrictive lifestyle that conforms to the restrictions imposed on them by psoriasis.

*Claire: I just, I lost all my confidence I, you know, stopped wanting to go out 'cause I could never wear the clothes that I wanted to wear, stopped dating 'cause I didn't want, you know.. I mean, my personality completely changed, and it all just stopped, and now I just do everything again. I just do everything that I've always done beforehand but literally for a year I felt like my life stopped. (686-699)*

In this context, participants talked about being helped to go through a process of reflecting on their experience of living their life with psoriasis and address the dramatic, for some of them, change caused by the loss of their former self. They were then able to rekindle with elements of their pre-psoriasis lifestyle. For example, Claire described how she experienced this change and noted how her feelings of grief turned into acceptance after she addressed the meaning of the perceived loss of her former self and revisited her prior-to-psoriasis lifestyle:

*I was definitely depressed, you know, but not anymore! (laughs), I am fine! It's just weird, 'cause I don't, it was not me..like, I became somebody I didn't like, a totally different*

*person, I didn't recognise myself anymore..and it was scary. I was like: "Who's that girl there 'cause that's not me at all!". But I couldn't get myself out of it, I couldn't see the light at the end of the tunnel, I just thought this is, you know, this is my life now. I just worked and I stayed in and I didn't go out with my friends anymore, you know, extreme reaction to it, I think, I had..Am very happy 'cause I don't like that person at all! (Laughs)(709-734)*

*d) Challenging the negative meanings attached to psoriasis.*

This category is intended to describe the impact of cognitive restructuring on the negative meanings the participants had attached to their skin condition. The results showed that the participants managed to challenge these negative meanings mainly through accepting the chronicity of psoriasis.

Participants spoke about being helped and guided by their therapist to make sense of their situation and come to terms with psoriasis being part of their lives and in particular with its chronicity and incurability. This helped them process and challenge the negative meanings previously attached to living with psoriasis and as in Becky's case "put psoriasis in perspective".

*Becky: So I don't fear it and I don't despise it..I could sense it coming back, I could feel it coming back and I did come here and got some help because it's going to come back, but it (i.e., CBT) helped me certainly to put it in perspective. So,ehmm, CBT has helped me come to terms with it (i.e., psoriasis) better than I was originally with it (465-474). . . I think I've been..I've come to the realisation or been helped to come to this realisation. (634-636)*

Similarly, Martin acknowledged the chronicity of psoriasis, which is one of the illness beliefs, and admit to expecting another flare-up in the future regardless of any medical treatment.

*Martin: "But then again, it is coming back, it's creeping back, it will find a way to come back..and that's what am expecting to happen with any medication"(499-501).*

The process of challenging their rigid and negative perceptions of psoriasis helped them develop a more accepting view of it. Their post-therapy views included less negative perceptions of it but not a full acceptance of it as part of their lives. They went from outright hating it to just disliking it. Others managed to make peace with psoriasis. They acknowledged that due to the chronicity of psoriasis the process of counteracting their negative views would be a lengthy one. The examples below illustrate participants' views of psoriasis before their CBT treatment and their more positive post-treatment perceptions.

*Martin: I accepted that, but I don't like it. I wish I didn't have it, but I accept that "Ok, I've got psoriasis and I have got to deal with that". It is easier though, it is easier than it was before (541-558)..I am annoyed with that, maybe I accept it (i.e., psoriasis) a little bit easier now. I found it very difficult to accept it before. There was a point when, if you get me a knife I would have cut my legs because I hated psoriasis so much, I don't feel the same way now, but I don't like it. (571-578)*

*Stephanie: I think it (i.e., CBT) helped me to feel more at peace with psoriasis. More at peace..I think I felt calmer and more at peace. (448-455)*

*Claire: I still have it, but it does not bother me, it doesn't bother me. I mean I have some on my legs and a bit on my arm but it really ..if this is the best it's going to be, am fine with it, you know(572-578). . . I mean that's part of the process is you know, maybe this is*

*it, maybe it's as good as it's gonna get, so just accept it, you know, it really doesn't bother me. (592-595)*

The results showed that by challenging the negative meanings attached to psoriasis, they experienced a process of adversarial growth wherein psoriasis was considered as a vehicle for change. Claire talked about how the psychological distress of psoriasis was the primary reason she engaged in CBT, and through this therapeutic experience, she managed to explore and overcome stressors that exacerbated her condition and deal better with her overall emotional difficulties. Retrospectively, she attributed her adversarial growth in part to the onset of her psoriasis.

*Claire: I remember there was one phrase that stuck with me where my therapist said "One day you may thank your psoriasis"..and I said "I will never thank my psoriasis, it's disgusting and I hate it" and, and, you know, I was very adamant, and actually, funnily enough, if I hadn't gotten psoriasis maybe I wouldn't have changed my lifestyle. So, that phrase stuck with me because I couldn't imagine at any point, when I was in the middle of feeling bad and being very upset, I couldn't for one moment imagine why I would ever like my psoriasis and, two years later I found myself, it helped me sort myself out, because I think perhaps if I hadn't gotten something so external that affected me so much, that I probably would have had some sort of mental breakdown at some point. So in some ways it kind of was the warning signal, I think. (266-283)*

Part of the cognitive restructuring and the participants' experienced adversarial growth was related to developing a better understanding of self and increasing their levels of awareness of their needs. The examples below illustrate the participants' views of achieving self-awareness.

*Emily: And as I progressed, because I think what was good about the therapy was that it helped me thinking or being more aware of what was going on (96–99). . . I’m actually a positive person. Doing that (i.e., CBT), helped me thinking more straight and being more aware. (152–154)*

*Tom: But also, with the CBT, sometimes it makes me more conscious of who I am, of the way I think about things. (180–183)*

*Martin: CBT helped me to understand that “This is what you are doing and that’s maybe why you have so much pressure there, and you are taking on board [everything]” (121–124)*

As a result, they developed a more respectful and gentler approach towards self, which led to self-compassionate attitude to self. For example, they talked about giving more time to themselves and valuing themselves more. *Becky: “It made me try and think about myself and value myself, give myself time.” (128–129)*. This compassionate approach motivated them to make positive behavioural changes and promoted greater acceptance of self and positive self-perceptions:

*Steven: However, now, after coming out of the bath and wet, I feel clean. I look at myself and, you know, start shaving, I say “That’s not too bad”, you know (609–612).. “I am worthy”, right. “I’m not a complete ogre” and, you know, “unworthy and so on and so on”, and if I’m worthy and if I can be of use to other people, maybe I should also be of use to myself, right. So all this consolation, it’s, you know, these are new sentiments. (707–713)*

## **Discussion**

### **Overview**

This chapter discusses the significance of the findings and considers them in relation to the research question and the existing literature in the field. The first section reviews the emergent model in relation to the current literature by refining, extending and challenging the extant theories in the field. The subsequent section outlines the methodological considerations and examines the limitations of the study. This is followed by a discussion of the implications of the research findings and directions for future research. Finally, the researcher's personal reflections on the research process are presented and followed by concluding remarks.

### **An Emergent Model of Guided Therapeutic Growth: Theoretical insights**

Research suggests that the use of CBT for people with visible differences, part of which include skin conditions, can be beneficial because the outcomes have shown favourable changes in anxiety, depression, social anxiety, quality of life, self-esteem and appearance-related anxiety (Clarke, Thompson, Jenkinson, Rumsey, & Newell, 2014; Clarke, 1999; Papadopoulos et al., 1999; Walker & Papadopoulos, 2005). Specifically, for psoriasis, CBT has similarly been beneficial with studies showing reductions in psychological distress, psoriasis disability and stress outcome measures (e.g., Fortune et al., 2002). However, notwithstanding its positive outcomes as a therapeutic intervention, more research evaluating the effectiveness and appropriateness of CBT is required. Indeed, seminal authors have encouraged clinicians in this field to produce evidence of what works for whom and help the clinical community understand how they can better support these individuals (Norman & Moss, 2015).

Taking account of users' experiences and their needs is a useful way of understanding how clinicians can better help clients. Clients are the *raison d'être* for therapy (Neenan & Dryden, 2004) and their thoughts, feelings and feedback on aspects of their therapy that produce change should be the focus of the enterprise (Elliott & Williams, 2003). Similarly, according to the National Health Service Objective involving the patients in the planning and delivery of mental health services should be pertinent (Department of Health, 1999). Therefore, research appreciating service users' perspectives on their treatment has increased (Glass & Arnkoff, 2000).

Considering the above, this study gave voice to the views of nine service users with psoriasis who have received CBT as part of their medical care in order to identify what they believed has contributed to the outcome of this form of treatment. Contrary to an RCT study, the present qualitative study was not concerned with providing details about the clinical significance of change. Instead, through exploring users' perspectives, it tried to add to the evidence base by explaining the *process* of change and providing information regarding the real-world context of the Psychodermatology service. It used a research design (i.e., Constructivist Grounded Theory) that mainly studies processes and adopted a Practised-Based Evidence (PBE) approach validating the subjective experience and acknowledging the complexity of the therapeutic endeavour (Lane & Corrie, 2006). Based on nine participants' experiences of their CBT as an adjunct to their medical treatment, an emerging model of CBT as part of the care of patients with psoriasis was developed, namely the Guided Therapeutic Growth model.

Four interlinked concepts were found to compose this emergent theoretical model. They were identified by the participants as influencing their psychological management using CBT as part of their medical care of their psoriasis. These concepts included: feeling engaged with the therapeutic process, establishing a trusting, collaborative and non-judgemental therapeutic relationship, having the distress around psoriasis legitimised and restructuring cognitively the meanings attached to psoriasis. The overarching concept that emerged as having the greatest links with all the above categories and acted as a unifying process was that of Guided Therapeutic Growth. This overarching process provides a comprehensive representation of the complexities of the emergent factors, the relationships between them and the dynamic nature of the therapeutic process.

An important finding reported by the participants, and which supports the literature, was feeling engaged with the therapeutic process. Client engagement is one of the main ingredients of therapy in most therapeutic modalities because it helps the client become more active within the therapeutic process leading to positive treatment outcomes (Orlinsky, Grawe, & Parks, 1994). Additionally, it aids the development of a strong therapeutic relationship because, as literature reports, the more engaged the client feels, the greater the bond with the therapist (S. Thompson, Bender, Lantry, & Flynn, 2007).

For the participants of this study, feelings of engagement were directly associated with having their expectations of their CBT treatment being explored. This was deemed important because participants' expectations ranged from unrealistic, such as expecting to experience an immediate effect on psoriasis after receiving CBT, talking about earlier life experiences and exploring

relationships with parental figures, to more realistic ones such as expecting to speak about and focus treatment on their current difficulties. In order to avoid confusion, misunderstandings and feelings of disappointment in relation to what CBT offers, this study proposes that the therapist needs to explore each patient's views and expectations of their treatment, manage any unrealistic ones, and focus interventions on how current psychological symptoms affect their psychological well-being and the progress of psoriasis. The patient can thus feel more engaged, understand where CBT places its focus of work and focus on current stressors abiding in this way by the CBT principle according to which CBT looks for ways to improve the individual's current state of mind (e.g., Beck, 1995; Westbrook, Kennerley, & Kirk, 2011).

The importance of exploring patient's expectations is further pertinent because unrealistic expectations are very common amongst people with appearance-related concerns. These individuals often present to clinicians requesting a treatment that will not only target the condition but will help them change their lifestyle such as start a relationship (Clark et al., 2014). They often get angry and disappointed when clinicians fail to meet their unrealistic expectations. Similarly, in this study, although the participants did not feel angry with their therapist, they experienced a sense of disappointment when they realised that CBT is not a fix-it solution that can ultimately "fix" their psoriasis. Rather it is a process of eliciting expectations and realistically modifying them.

A factor that appeared to have influenced participants' expectations was the media. There were participants who had formed misconceived expectations based on the information they had sought out on the Internet before commencing CBT. Studies in the UK have shown that looking

for medical information is exponentially increasing as one in four patients are accessing health information from the Internet (Akerkar & Bichile, 2004). The so-called “e-patient” can in some cases make a more informed choice because they have easy access to the latest healthcare developments and because various treatment modalities for many conditions are easily accessible. However, in this age of oversupply of information on the Internet where there is significant variability in the quality and reliability of the information, people risk being exposed to misinformation and misconceptions regarding their treatment. As a result, people can form false beliefs similarly like some of the participants in this study, and false beliefs can weaken confidence or motivation, which then affects compliance and engagement (Clark & Beck, 2012). Identifying and clearing away any false expectations is therefore important because they may act as potential barriers to change, sabotage engagement in treatment and jeopardise subsequent progress in therapy.

Setting specific and realistic goals was another finding of this study that countered unrealistic expectations and further assisted the process of engagement in CBT. CBT is a time-limited approach and one of the ways to maintain its efficiency is to work towards agreed goals (Westbrook et al., 2011). Indeed, this study confirms the literature, according to which a significant part of the CBT contract is setting therapeutic goals that are realistic, relevant to each patient’s problem and as specific as possible (Whitfield & Davidson, 2007). Such goals help the patients feel more in control because problems are perceived to be more manageable and more structured, and CBT as more organised (Westbrook et al., 2011). In this way, patients maintain their focus and feel more engaged in the process. Goal setting has also been emphasised by Clarke and colleagues (2014) who suggests that goals should be negotiated rather than imposed

providing an opportunity for collaboration and assessment of the progress of treatment. Similarly, the participants of this study spoke about a process of facilitation and encouragement towards setting their personal goals rather than enforcement and imposition.

Setting realistic and specific goals, which are often described in literature as Specific, Measurable, Achievable, Relevant and Time-limited–SMART goals–(Beck, 1995), is not a new finding of this study. However, this study further stresses the importance of this basic CBT principle particularly for individuals with psoriasis, who similarly to individuals with a visible difference are reported to have low expectations of what they can achieve because of low confidence (Hughes, 1998). Therapeutic goals set the stage for either the possibility of feeling pride of accomplishment when goals are met or the potential for suffering sadness and dejection in the wake of persistent goal failure (O’Donohue & Fisher, 2012). Patients with psoriasis are reported to score high on the failure schema, predicting psychological distress (Mizara et al., 2012). The failure schema is associated with self-critical thinking such as one being “stupid and untalented” and the belief that one is fundamentally “inadequate and a failure” (Young et al., 2003). In this study, the lack of clear, well-defined and realistic goals was therefore found to trigger self-critical thoughts derived from a sense of failure–commonly experienced by individuals with psoriasis–that led to feelings of frustration, confusion and disappointment. No matter how hard they tried to work on achieving their goals, if these were unrealistic and not well-set, the participants could not succeed and overcome a sense of failure. Therefore, establishing specific and realistic goals that are structured, easily understood and achievable can encourage and motivate these patients. This finding is in line with the Appearance Research Collaboration (ARC) study according to which planning simple steps helps the individual feel

that they have achieved something (Clarke et al., 2014). In this way, patients feel less helpless in the face of what might initially seem insurmountable problems.

Exploring further the components of the model of Guided Therapeutic Growth, psychoeducation and in particular helping the patient understand the mind-skin link was found as another contributory factor to the CBT outcome. Before commencing CBT, participants of this study were not fully aware of the connection between their thoughts, feelings and behaviours and how these can be related to any psoriasis' flare-ups. The process of helping them understand this connection fostered feelings of empowerment, a sense of control and prepared them to better deal with flare-ups. Indeed, literature suggests that increasing patients' understanding of their condition helps them make productive changes that foster coping with the consequences of their illness (Gonzalez-Pinto et al., 2004).

Interestingly, psychoeducation is reported to be based on a biopsychosocial medical model that utilises an educative approach. This approach could stand in tension with Counselling Psychology's principles that interrogate the medical model and emphasise the well-being instead of diagnosing, pathologising and using labels to describe difficulties (Strawbridge & Woolfe, 2010). However, if CBT utilises psychoeducation in a friendly, engaging and interactive but not lecturing style, then the individual does not feel labelled or, as the experiences of these participants indicated, as a compliant student being required to do homework; rather they are armed with knowledge that will help them reduce the risk of a relapse (Wright, Ramirez- Basco, & Thase, 2006). Similarly, the results of this study confirm these benefits of psychoeducation as the participants were guided to gain a better knowledge of the psoriasis-skin link, their psoriasis

flare-ups and the two-way relationship between psoriasis and stressors from their daily life, feeling better prepared to deal with flare-ups.

Within this concept, another integral component of CBT (Beck, 1995) emerged as contributing to the psychological management of psoriasis namely having homework assignments. Homework helps with the continuity of making changes and gives clients the feeling it is they who are doing the work, rather than the therapist waving a magic wand (Beck, Rush, Shaw, & Emery, 1979). The participants in this study spoke at length and emphasised the benefits they derived from homework. Thought diaries enabled them to record, monitor, evaluate and respond to negative thoughts. Homework also helped them review the learning process, sustain the momentum and engage in self-reflective processes that, according to Rennie (1992), is a central task in therapy.

Within the process of assigning homework, what was emphasised as particularly helpful was the therapist's guidance and direction towards homework that was relevant and specific to each individual's needs. Well-thought and tailored to individual's needs homework helped the participants relate to the therapy material, refresh their memory, develop a reflexive stance toward their everyday life demands, and thereby achieve a better understanding of themselves and possibly their reactions to their skin condition. This is consistent with Bennett-Levy's (2003) argument that becoming aware of internal processes is a key feature of useful homework assignment.

Notwithstanding the majority of participants' accounts indicating that adherence to technical aspects of their CBT therapy (such as homework) carries benefits such as therapeutic change (Burns & Spangler, 2000; DeRubeis & Feeley, 1990) and the development and maintenance of a strong therapeutic alliance (Bedi, Davis, & Williams, 2005), there were also participants who perceived homework as less useful in their CBT sessions. For those participants, homework was associated with unpleasant school memories and was perceived as an obligation. They said it did not suit their needs and did not help the development and sustainment of the therapeutic learnings and growth, such as increased awareness. Research supports that clients, who find the assignment of homework to be less helpful and who are less adherent, are resistant to the therapeutic process and usually tend to do worse with technique-oriented therapies such as CBT (Beutler, Machado, Engle, & Mohr, 1993; Beutler et al., 2004). Similarly, clients who are more likely to do well in therapy are the ones who complete homework and engage with the therapeutic tasks (Kazantzis, Whittington & Dattilio, 2010; Mausbach, Moore, Roesch, Cardenas, & Patterson, 2010). Likewise, Neimeyer and Feixas (1990) found that undertaking homework assignments predicted more substantial improvement in symptomatic features of depression, reinforcing the value of homework in improving treatment response.

Literature suggests that lack of engagement with homework, can be related to lack of motivation, lack of understanding, a perception of homework being too structured for one's problems, or an unwillingness to revisit one's difficulties (Wiles et al., 2014). For individuals with psoriasis the lack of engagement in homework might also be related to a fear of negative evaluation. These individuals are often reported to already evaluate themselves negatively and fear that others might criticise them. Engaging in the process of homework could be associated with a feeling of

being assessed that could potentially trigger negative thoughts such as “Others are judging me” or “I am not good enough”. Therefore, by not adhering to homework patients could be protecting themselves in case they did not have anything to record or monitor, or in case the outcome could be construed as falling short of the therapist’s expectations (Westbrook et al., 2011).

Consistent with the aforementioned literature, the results showed that homework can be a challenging experience for some patients with psoriasis, jeopardising therapeutic progress and preventing processes of self-reflection and further engagement in therapy from taking place. As such, setting homework needs to be handled with care. Within a CBT framework the therapist needs to establish from the outset and regularly remind the patient that homework is an integral part of therapy and provides essential information and feedback that is of benefit to the patient and supports the achievement of the therapeutic goals. Great attention should thus be placed on staying true to the fundamental principles of CBT protocol while still accounting for subjectivity and individual needs and perceptions (e.g., fear of negative evaluation). Finding this balance between technical factors and individual needs is instrumental. At the same time, non-adherence can be used in an exploratory fashion, and help the therapist understand whether practical reasons or underlying negative self-beliefs have hindered the process of completing the tasks. Interestingly, contrary to findings from certain previous studies in this field, such as the ARC (Clarke et al., 2014) and FACEIt (Bessell et al., 2012), which highlighted the importance of incorporating practical tasks, the participants of this study did not mention homework interventions in much detail. They did not express the need for more practical tasks involving exposure therapy nor ways to build better social skills. These procedures and interventions have a good success rate in reducing social anxiety, which is a key difficulty for individuals with

disfigurement (e.g., Newell & Clarke, 2000). It could be therefore supported that, for these participants, the therapy itself as an overall experience was so powerful and novel that it made them place less emphasis on the many different technical aspects of CBT and more on the experience of it as part of their overall management.

Helping patients engage with the therapeutic process is critical because resistance and scepticism about therapy is often encountered in people with appearance-related concerns who enter a CBT programme (Clarke et al., 2014). Additionally, the element of stigma attached to asking help for emotional difficulties deriving from skin difficulties makes the importance of engaging patients even more pertinent. The categories that formed this concept need to be addressed and explored at the outset of therapy in order to set the therapeutic scene and help patients feel more engaged in their therapeutic experience. This way, they can better understand the process of CBT and know what to expect, not feel lost or uncertain as to what to do, more motivated to embark on introspection and better prepared to develop a therapeutic relationship.

The process of establishing a therapeutic relationship that was trusting, non-judgemental and collaborative emerged as another factor that underpinned the theory of Guided Therapeutic Growth. The establishment of a positive therapeutic relationship between the client and the therapist is not a novel finding of this study. It has been extensively documented in literature as the sine qua non condition for the majority of therapeutic approaches (Clarkson & Pokorny, 1994; Gilbert & Leahy, 2007; Lambert & Barley, 2001; Roth & Fonagy, 2006). It has also been documented in Counselling Psychology as one of its main philosophical underpinnings that is embedded within the practice of therapy (Lane & Corrie, 2006; Strawbridge & Woolfe, 2010).

What this study found that was new was the identification and exploration of four interconnected dimensions that compose the concept of the therapeutic relationship as experienced and perceived by the participants of this study.

Under this factor, there was a common, shared belief among the participants about the importance of feelings of equality and collaboration within a non-judgemental environment. The therapist's non-judgemental acceptance of the client is crucial and a major source of client satisfaction that aids the development of a positive relationship (Mayer & Timms, 1970; Lietaer & Neirinck, 1987). Indeed, since Carl Rogers's work, therapist's acceptance and non-judgemental approach have been recognised as fundamental to the development of effective therapeutic relationships (Rogers, 1951). Particularly for individuals with psoriasis, feeling accepted was highly valued due to the fears of stigmatisation and rejection that often lead to anticipatory and avoidance coping behaviours, which are principal predictors of disability in these patients (Vardy et al., 2002; Hill & Kennedy, 2002; Richards et al., 2001) alongside their own negative beliefs about their condition and the negative reactions of others (Fortune et al., 2005). Additionally, people's attitudes towards them can evoke feelings of shame and loneliness (Sampogna et al., 2012) and lead the individual with psoriasis to social isolation and other interpersonal issues such as lack of trust (Moon, Mizara, & McBride, 2013). Therefore, patients' experience with a therapist who did not repeat this rejecting and isolating behaviour of the general public, instead they trusted them, enabled the experience of being in a trusting and positive therapeutic relationship that was empowering for the patients.

Leahy (2008) suggests that the therapeutic relationship needs to be regarded as an ongoing process because it is interactive and iterative. He explains that such a relationship may be a window onto prior or current relationships the patient has or had and acts as a reparative relationship. Similarly, a number of researchers have described the therapeutic relationship as a potentially secure place in which patients are securely attached to their therapist (Hardy, Cahill, & Barkham, 2007) and from there they can safely explore their difficulties (Boucher, 2006) and discover the world (Holmes, 1996). The findings of the current study strongly resonate with this literature because the therapeutic relationship was found to be a continuous process, providing the participants with a new and powerful experience of being with someone who did not judge them because of their condition. Particularly for individuals with psoriasis who often report experiences of stigma, negative evaluations, public rejection, and reactions of disgust (Ginsburg & Link, 1989; Henry, 2011), this caring and trusting environment wherein they felt accepted, was thought to be of great significance because it contradicted such past negative experiences and fostered the capacity to question negative self-beliefs and see themselves as being of value for who they are, moving away from self-hatred on a journey to greater self-acceptance.

Literature takes the view that CBT is based on empiricism and places an emphasis on client agency (Nelson & Borcovec, 1989) by giving clients an active part to play in the process (Dryden, 1995). Indeed, the results of this study showed that the collaborative nature of the therapeutic relationship was highly appreciated by the participants. The absence of power issues within this therapeutic dyad contributed to such sense of collaboration. Participants described a collaborative bond with their therapist and its significance in facilitating processes of self-exploration, personal reflection and self-understanding. These results are consistent with the

literature, according to which patients who feel and perceive the therapeutic relationship as collaborative are less resistant and more open to exploration and change (Cully & Teten, 2008), and tend to do better in therapy (Orlinsky, Rønnestad, & Willutzki, 2004; Tryon & Winograd, 2011). The collaborative approach has also been adopted in a patient-led organisation “Changing Faces” wherein the therapists have moved away from promoting a passive and receptive role for the patient and instead have encouraged patients’ active participation in the management of their condition. This way, the patient feels more engaged, understands the problem better and is more willing to try out and develop new coping strategies (Clarke, 2001).

Demonstrating one’s openness to having a constructive dialogue about how therapy is progressing is a useful way to explore how the therapist responds to patients’ needs and to strengthen the therapeutic relationship, resulting in fewer therapeutic ruptures and dropouts (Clarke et al., 2014). In line with the literature, the results of this study also showed that asking for patients’ feedback and encouraging them to voice their views about their therapeutic experience fostered the collaborative element of CBT and solidified the patient-therapist relationship.

Within this trusting and non-judgemental therapeutic relationship, maintaining suitable levels of directiveness was also emphasised by participants. Erring towards either too much or too little directiveness appeared to have hindered therapeutic progress. On one hand, participants felt overly-led, criticised and challenged, on the other hand they felt directionless, unchallenged and lost. In either case, the therapist was not attuned to the patient’s moment-to-moment emotional experience and frame of reference, thereby jeopardising the therapeutic process.

CBT is known as a directive approach (Dryden, 2013). Evidence suggests that directiveness can lead to positive therapy outcomes because the therapists direct the patients towards deeper and more productive levels of therapeutic work that might otherwise have stayed on the surface (Sachse, 2004). Additionally, patients associate this directive behaviour with conveying interest and care (Maluccio, 1979) so long as they do not feel too challenged (Lietaer & Neirinck, 1987). The findings of this study confirm the beneficial aspects of directiveness in aiding therapeutic change and reinforce the view that maintaining suitable levels of directiveness, according to individual's needs, is what patients perceive to be a useful component of their treatment.

On one hand, this study showed that when the therapist did not provide sufficient levels of directiveness or did not challenge them enough, then the patients reported feeling unchallenged, directionless and as if not achieving change. On the other hand, the study also identified potential risks associated with therapists who are more directive than is appropriate for a given patient. The literature suggests that over-directiveness can lead to client resistance (e.g., clients withholding critical information from the therapist) and non-compliance (Dryden, 2013; Williams, 2002). It has also been reported that highly directive therapist approaches are associated with poor outcomes because patients cannot come to their own understandings slowly and gradually (Glass & Arnkoff, 2000; Paulson, Overall, & Stuart, 2001). For the participants of this study who perceived their therapist as overly directive, it could be hypothesised that feelings of stigmatisation, criticism and rejection—often experienced by individuals with psoriasis—were potentially re-enacted, making them feel overly challenged and criticised, thereby jeopardising progress. Therefore this study suggests that, for this group of patients, the therapist needs to be

attuned to the patient's needs at each moment and appropriately respond to the level of directiveness needed for each individual without erring on too much or too little directiveness.

This research further suggests that the element of empathic attunement played a significant role in maintaining suitable levels of directiveness. Empathic attunement is a key element of the multi-dimensional concept of therapeutic empathy (Thwaites & Bennett-Levy, 2007). It enables the therapist to “operate within the internal frame of reference of the client . . . listening from the inside as if ‘I am the other’. . . being attuned to the nuances of feeling and meaning, as well as the essence of another's current experience” (Greenberg & Elliott, 1997, p. 167–168). In this study, empathic attunement helped the therapist understand the patient's moment-to-moment emotional and cognitive state and be empathically directive, (i.e., determine how much or little directiveness they needed to provide while remaining sympathetic), thus being perceived as neither critical nor uninvolved.

The significance of empathy within CBT has been supported by a large body of literature as one of the key ingredients in promoting therapeutic change (Beck, Rush, Shaw, & Emery, 1979; Bohart & Greenberg, 1997; Rogers, 1967). A meta-analytic study showed that the effect sizes for empathy in CBT are higher than in studies of other theoretical orientations (Bohart et al., 2002). This is because in therapies such as CBT that use more technical interventions, empathy is more essential and important for such interventions to take place (Cooper, 2008). Furthermore, empathy is central to the establishment of an effective therapeutic alliance (Bohart et al., 2002; Hardy, Cahill, & Barkham, 2007), promotes access to the patient's inner world, enhances exploration and meaning creation, and provides a corrective emotional experience that does not

reinforce old negative emotional experiences (Jordan, 2003). When the client perceives the therapist as lacking empathy, then the therapist is experienced as being dismissive and invalidating, leading to a negative therapeutic outcome (Leahy, 2008). Therefore, although CBT can be considered a directive and possibly confrontational approach, when practised by a skilled CBT therapist who can modify their interaction style in order to accommodate each client's needs, then it can lead to positive outcomes (Dryden, 2013).

Additionally, receiving feedback from the therapist emerged as another process contributing to the outcome of CBT because it was associated with the collaborative nature of their therapeutic relationship. In line with the literature, the results of this study confirm the great therapeutic gains clients can experience from receiving feedback (Copper, 2008). The study showed that when the therapist did not provide feedback, participants commented negatively on it, felt unsupported and less engaged with the process, and the therapy seemed open-ended. This finding is consistent with a US study showing that clients who are given feedback (e.g., on psychological assessment scores) experience more therapeutic gains in comparison to those who have not.

Thwaites and Bennett-Levy (2007) describe regular client feedback as a CBT intervention and strategy that can promote empathy and assist the therapeutic relationship. Similarly, the APA Division 29 Task Force suggested that providing feedback is a powerful intervention and a promising and probably effective element of the therapeutic relationship (Steering Committee, 2002, as cited in Cooper, 2008). Therefore, this study emphasises the importance of providing feedback and concludes that it is amongst the factors that contribute to this group of individuals' therapeutic experience.

Another important process affecting the establishment of a good therapeutic relationship was the nature of the pre-existing physician-patient relationship. Participants explained that in this particular psychodermatology service the clinical team did not focus just on the clinical symptoms. Rather, they provided a wider understanding to the patients incorporating psychological aspects in their management of psoriasis. They informed the patient about the role of a psychodermatology service and they facilitated a referral. Furthermore, the referral was negotiated collaboratively, which made the patients feel respected, understood and as an equal part of a team. The participants contrasted this holistic approach and the understanding they received from the clinical team with previous negative experiences of their first-line medical treatment that completely lacked awareness of the psychological distress associated with psoriasis. This lack of awareness had left them feel helpless, hopeless and disappointed. Research suggests that GPs who are the “gatekeepers” to psychological support services, find it hard to identify appearance-related distress and underestimate, or are even unaware, of the psychological impact on the individual’s life (Clarke, 2001). As a result ineffective treatments are prescribed, with poor outcomes, or unnecessary referrals are made, which impact patients’ trust in the health service leading to increased costs for the NHS.

It has been well documented in literature that the physician-patient relationship in psychocutaneous medicine is of crucial importance as it affects the outcome of the treatment, adherence to the treatment and coping with the disease (Rumsey & Harcourt, 2004). This relationship is ideal when the patient is the expert on his/her symptoms and the doctor is the expert on the treatment. Traditionally, though, the relationship between the physician and the patient was asymmetrical; that is to say, doctors had significantly more information about

medical conditions than their patients and they were the only expert ones who decided the patients' treatment. Over time, the focus of power in health care began to shift: instead of the doctor acting as sole manager of patient care, or as "the captain of the ship" (Akerkar & Bichile, 2004, p. 121), a consumerist model has emerged in which patients and their doctors are partners in managing the patient's care. Within this model, the concept of mutuality plays an important role in the physician-patient relationship as it represents a shared approach to decision making.

The participants of this study stressed the importance of raising awareness of the psychological distress resulting from psoriasis, supporting the need for further training in identifying and dealing with the psychosocial needs of those affected by appearance related concerns. This way, clinicians will better understand what these individuals are going through, treat the individual as an expert on their symptoms and collaboratively promote appropriate referrals for support (Clarke et al., 2014).

In summary, the findings of this study suggest that the process of developing a therapeutic relationship is one of the factors that the participants described as essential. Feelings of acceptance and collaboration were highly emphasised within this relationship because they facilitated a team approach that engendered mutual understanding, shared goals and responsibilities. Such approach disconfirmed their previous rejecting, stigmatising and judgemental experiences. The patient-physician relationship was an inextricable factor affecting participants' experiences and was positively commented by all of them during this study. A diversity of experiences was reported in relation to levels of directiveness, an imbalance of which was considered as hindering the CBT therapeutic work. CBT considers the therapeutic

relationship as necessary for therapeutic change, but it does not think it as sufficient (Westbrook, et al., 2011). Cooper (2008) also suggests that a good therapeutic relationship is not the only factor that accounts for therapeutic change. Although for the participants of this study the therapeutic relationship was indeed an important factor of their therapeutic experience, yet it was not the sole contributor to patients' psychological management and that other factors and processes were also found to be present and contribute to the outcome.

The factor of feeling engaged in the therapeutic process as well as the ingredients of a well-established therapeutic relationship, such as feeling comfortable and safe and not criticised or judged, appeared to provide the basis for non-burdening self-expression and aided further engagement in therapy for this group of participants. Self-expression was described as a process that facilitated self-exploration and led to the development of introspection and personal understanding. This was a novel experience for this group of individuals during which they were given the space to talk about and offload their distress without feeling like a burden and without having their concerns dismissed. Individuals with skin-related concerns frequently experience upsetting situations whereby others are unable to understand their skin-related distress or consider them vain for being concerned about something as minor as a skin condition. Participants benefited from a process whereby they could express their emotional distress and the therapist would not minimise it but instead acknowledge and explore it. This "permission" to explore painful feelings was one of the essential factors that made self-expression therapeutic and helped the participants achieve therapeutic growth.

The opportunity to express one's self scores high on the list of what clients find most helpful in therapy (Feifel & Eells, 1963) because they experience a sense of relief (Mayer & Timms, 1970), so long as they talk with someone who listens and who is being perceived as a real person rather than "a technical junkie" (Howe, 1993, p. 24). Participants of this study also described the process of self-expression as important and helpful and explained the reasons that made it unique. Firstly, they contrasted this novel experience of self-expression within a therapeutic setting with talking to their family and friends about their distress. Within therapy, not only did the participants feel encouraged to express themselves but they also did not feel that their emotional pain was invalid or exaggerated. It is by letting patients express themselves, their emotional problems, their fears and hopes that a therapist can empathise with them and understand them better (Papadopoulos et al., 2002). Secondly, expressing their distress to their family and friends was often associated with feelings of discouragement and guilt, which made them feel unsupported and misunderstood. On the other hand, the process of self-expression to their therapist was facilitated by a therapeutic setting wherein patients were given the time and the attention needed to express their emotional pain without feeling as if they moan or burden the therapist.

Another important finding that confirmed the broader literature on skin conditions is the process of legitimising the expression of the distress associated with the skin condition, in this case psoriasis. Individuals with appearance related concerns are often told that their distress is out of proportion to their appearance (Clarke et al., 2014). However, severity does not predict distress and those with a minor objective disfigurement may experience high levels of distress (Moss, 2005). Having someone who did not dismiss patients' psoriasis-related concerns and did not

attempt to reassure them by commenting on the objective appearance, was of unique significance to participants because it indicated that their problem had been listened to and understood. Clarke et al. (2014) suggest that framing appearance as unimportant is a pitfall in therapy, especially for these individuals to whom appearance carries a high premium and whose fear of being judged reinforces the negative appraisal of their appearance. Discussing their appearance-related issues enhances normalisation of distress and the clinician's interest fosters feelings of acceptance, making the therapeutic relationship stronger (Clarke et al., 2014). Equally, for the participants of this study, externalising their psychological distress and having the expression of their distress legitimised by their therapist aided the process of distress normalisation. Within this non-invalidating environment, as offered by their therapist, participants felt reassured that their feelings are common amongst people with psoriasis and that expressing them is acceptable. Normalisation also helps reduce the stigma associated with seeking psychological support because individuals understand that their problems are common among people with similar conditions (Rosen, 2003). As a result, participants felt relieved and maintained a stance of disclosure without avoiding painful aspects of their experience or trying to emotionally protect others. This process helped these individuals with psoriasis experience a sense of fitting in and relating to others, and it normalised their experience even further.

Another positive finding of this study in relation to self-expression was the opportunity and the space that patients were given to speak about other stressors in their lives that might have a direct or indirect link to psoriasis. As a result, they felt that the therapist was going beyond appearance-related distress and was focusing on the person behind the skin condition. By not just focusing on the skin condition, the therapist can better understand the individual, see the person beneath

and help them move towards coping with and accepting their condition (Papadopoulos et al., 2002). This finding of the study is therefore a useful reminder that appearance concerns may not be limited to the direct consequences of the disfiguring condition. Rather, appearance dissatisfaction is multi-factorial in nature and is often an amalgam of several issues that affect the emotional wellbeing.

It was worth noting that some participants found the process of self-expression challenging, especially during the initial phases of the treatment. When they perceived their disclosures as too revealing or when they felt as if they had shared too much, this triggered uncomfortable feelings and they became withdrawn and reserved from the process. This challenging experience might be linked to the fact that individuals with skin conditions are too self-conscious to express their emotional discomfort and reluctant to seek help, because they fear what others will think of them (Henry, 2011) and want to prevent feelings of rejection, embarrassment or humiliation. It could also be linked to these individuals' inability to express emotions. Alexithymia is an enduring characteristic that has been investigated more comprehensively in psoriasis and is related to individuals who amongst other symptoms have difficulties identifying and/or describing feelings (Fortune et al., 2004). It is suggested that this poor emotional regulation may lead to undifferentiated affect and poor psychological adjustment, a lack of psychological mindedness and difficulties in the self-regulation of emotion (Ginsburg, 1995). Therefore, it is a risk factor for the emergence and maintenance of distress (Fortune et al., 2005) that could have impacted the process of self-expression for these participants. Drawing from schemas' literature, it could be suggested that the process of self-expression becomes even more challenging for individuals with psoriasis because they score high on the emotional inhibition schema. This schema is

related to a difficulty in discussing and expressing their emotions or communicating their needs (Mizara et al., 2012).

Additionally, the challenging element of self-expression could be associated with fear of negative evaluation (Kent & Keohane, 2001), feelings of shame and embarrassment (Jowett & Ryan, 1985) and with the belief that others will reject them (Weiss et al., 2002); all of which are common among individuals with psoriasis. In order to prevent further humiliation, the individual hides his or her psychological aspect from others (Fortune et al., 1997), which often leads to anticipatory behaviour (Hill & Kennedy, 2002). Based on this literature, it could be hypothesised that the participants who were more reserved in their self-expression did so potentially as a way to prevent further humiliation and rejection, suggesting that they might have felt ashamed or rejected. This further emphasises the importance of establishing a therapeutic relationship based on feelings of support, acceptance and understanding that would make it less likely for the patient to withdraw from the process of self-expression. Acknowledging that there are many different reasons that self-expression can be experienced as challenging, this finding highlights the need for practitioners to pay great attention to possible deficits of patients with psoriasis in the process of self-expression and respond to moment-to-moment needs accordingly in order to facilitate this process and unblock therapeutic growth.

The last factor that emerged is related to one of the principle practices in CBT- the identification of and work with dysfunctional thoughts (Beck, 1995; Castonguay & Beutler, 2006; Dickerson, 2000; Gilbert & Leahy, 2007). CBT is concerned with helping clients become aware of their

cognitions and in particular of how they perceive themselves and others, and aims to substitute any negative thinking with a more balanced and realistic one (Culley, 1992).

Individuals with skin conditions have established schemata with a prevalent negative content and process information, assumptions and expectations in a biased way causing dysfunctional preferential attention and misevaluation of information (Clarke et al., 2014). Utilising a therapeutic approach that aims to address unhelpful schemata and negative self-perceptions was considered essential for these individuals. Indeed, the participants in this study positively commented on the cognitive element of CBT and explained how they were guided to restructure their dysfunctional thinking, accept characteristics of their condition, view themselves positively and consequently achieve therapeutic growth confirming the literature on the effectiveness of the cognitive part of CBT for skin conditions (e.g., Bessell et al., 2012; Papadopoulos et al., 1999; 2002). Apart from confirming the importance of the cognitive restructuring process, this study has also identified the specific elements that, according to the participants, have facilitated it.

One of the elements of the cognitive part of CBT that the participants described as helpful was the modification of thoughts related to a perceived sense of loss of control stemming from the unpredictable nature of psoriasis. Psoriasis is an unpredictable skin condition that results in excessive worry and uncontrollable distressing thoughts (Fortune et al., 2003). In particular, excessive worrying, which is perhaps the most widely cited psychological event in psoriasis (Fortune et al., 2000), impairs clearance of psoriasis (Fortune et al., 2003) and makes patients more vulnerable to the impact of daily stressors, increasing the severity of the psoriasis (Verhoeven et al., 2009). Although the participants could not control the element of

unpredictability, cognitive restructuring helped them regain some levels of control, believe in their ability to cope and thus worry less about the impact of psoriasis on their lives. Their ability to cope and feel more in control was further solidified by describing CBT as a coping toolkit. Indeed, CBT is considered an approach that provides clients with tools for the future by teaching them new skills and new ways of thinking and behaving (Wendt & Moulding, 2016). By taking such view, participants felt empowered and reassured because they knew how to act and what they needed to do, which increased feelings of control.

Additionally, the results of this study indicated that the participants' perceived sense of loss of control and the associated worry was caused by the possibility that the psoriasis might appear on visible parts of the body, such as on their face. The visibility and anatomic location of psoriasis with regard to distress can indeed be impactful for individuals with psoriasis. However, it has not been assessed adequately and the literature shows mixed findings (Griffiths, Barker, Bleiker, Chalmers, & Creamer, 2016). For example, Kent and Keohane (2001) found a relationship between anxiety and psoriasis in visible places, such as the face and hands. Other literature, though, takes the view that high levels of distress are experienced not only by those who have a difference in visible parts but also by those in less visible parts that can easily be covered (Moss & Rosser, 2008). For those with less visible disfigurement, the distress can be great and the adjustment low because the individual has not developed strategies to deal with the unpredictable reactions of others, which may feed insecurity (Lansdown, Rumsey, Bradbury, Carr, & Partridge, 1997). Those who have more noticeable conditions can adjust more positively because they know what range of reactions to expect from others, and they are more prepared and forewarned (Moss & Rosser, 2008). Therefore, evidence base of psychological research suggests that

visibility, severity and type of appearance condition are in fact not reliable predictors of psychological adjustment (Robinson, 1997; Rumsey, Clarke, & White, 2003). Present findings suggest that visibility in relation to the unpredictable nature of psoriasis could increase the perceived sense of loss of control and maintain distress and thus therapy should focus on restructuring these cognitions and help the patient regain their perceived sense of control.

Another important element of the cognitive restructuring process was the modification of maladaptive appearance-related schemas. Appearance schemas are cognitive structures containing core beliefs and conditional assumptions about appearance (Altabe & Thompson, 1996), they are related to self-worth and occupy an extensive part of people's self-worth (Moss & Carr, 2004). The interdependence of appearance and self-concept for people with visible differences has been documented in literature (Kent & Thompson, 2002; Thompson & Kent, 2001). For example, if someone has been judged negatively in relation to their appearance, this can have a detrimental effect on their self-esteem. Early cognition models of body image concerns have also suggested that an individual's thinking can become increasingly dominated by negative thoughts about their appearance (K. Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). The higher the appearance concern the greater the distress, because the way people process and interpret information is dominated by appearance issues that reinforce negative self-perception. In other words, the more central the appearance is in someone's self-concept, the less cognitively flexible the individual is in relation to their core views of themselves and appearance (Rosser, 2008).

For individuals with psoriasis, this concept can be highly negative and impactful. Due to their condition, they develop a devaluing sense of self and a sense of being defective. They consider themselves as different, flawed and unlovable and their appearance as abnormal (Fortune et al., 2012). Individuals with appearance anxiety often have exceptionally high standards of performance and believe that everyone should look their best and anyone who has less than perfect looks should not be tolerated (Clarke et al., 2014). Such rigid views reinforce the defective view of self and maintain the distress. Similarly, the participants of this study viewed their appearance as flawed and consequently evaluated their selves in a negative and self-critical way. They described compensating by pushing self to overachieve. The notion of self-criticism stems from a need to punish self for not having a “good enough appearance” and often results in avoidant-type coping and subjugation, causing severe appearance-related distress in the form of depression and anxiety (Clarke et al., 2014). This study suggests that therapeutic interventions need to address self-attacking and self-critical cognitive processing styles. By identifying the power and function of self-criticism, the underlying belief is revealed, which can then be targeted for cognitive restructuring. Clarke (1999) reports that therapy should aim to help clients become aware of their own cognitions around the perceived value and role that appearance plays in their life and how they judge themselves. In other words, identify the impact of valence (the positive or negative beliefs they hold about their appearance) and salience (body image investment) on patient’s view of self (Clarke et al., 2014). Bessell et al. (2012) support this view and state that this should be an integral part of the psychosocial intervention process. Apart from helping the patient become aware of their own cognitions, this study emphasises the importance of modifying these schemas. This cognitive modification includes: considering alternative views of self, processing information in a more flexible way, reducing perfectionism and revising rigid

self-critical beliefs. This finding was considered of significant therapeutic importance by this particular group of individuals because it aided the development of a sense of pragmatism, self-awareness and self-acceptance—all of which are among the coping strategies in positive adjustment (Egan et al., 2011).

Another factor of the theory of Guided Therapeutic Growth was related to processing the meaning that patients had attached to losing their former or ideal self. This loss was so intense for the participants of the study that it resembled a process of mourning and feelings of grief such as shock and disbelief. The package of care provided by Changing Faces emphasised the importance of helping the patient acknowledge feelings of bereavement for lost looks or for looks that one never had (Clarke, 1999). Consistent with this approach, the finding of this study supported the need of helping patients mourn the loss of their former appearance and lifestyle and process the meaning associated with this loss.

The perceived loss of an ideal or former self was maintained by internal comparisons between their imagined or undamaged self and their current one, which was perceived as abnormal. Individuals with disfigurement attach great value to appearance, and when there is a perceived appearance-related mismatch between actual-self and ought-to-self then this can result in excessive preoccupation, checking and distress (Price, 1990). Clarke et al. (2014) talk about the impact of social comparison processes and explain how the pressure exerted by socio-cultural standards results in actual-self versus ought-to-self discrepancy. This is because individuals experience a disruption to their sense of self and fall short of societal ideals. Although the participants of this study did not make social comparisons between themselves and others, they

experienced significant distress resulting from the discrepancy between their actual/current versus former or ideal self. Supporting the literature on the negative impact of this discrepancy, this study highlights the importance of processing the meanings attached to the perceived loss of a former or ideal self. It suggests that interventions need to help patients work through the associated feelings of grief, process the sense of lost identity and understand the meaning of the actual- versus former-self discrepancy on dominating and disrupting their current sense of self.

Lastly, a final factor of the emergent theory of Guided Therapeutic Growth was related to challenging the extremely negative meanings the participants had attached to psoriasis. What enhanced this cognitive process was an acceptance of the chronicity of psoriasis. Chronicity (also reported as illness perceptions regarding the timing or likelihood of recurrence) is one of the five broad cognitive dimensions that shape people's perceptions regarding their illness (Weinman, Petrie, Moss-Morris, & Horne, 1996). Particularly for psoriasis, strong beliefs about its chronicity have been illustrated to be important in accounting for disability (Scharloo et al., 1998). The participants of this study managed to overcome such illness beliefs and by accepting the chronicity of their condition they achieved therapeutic growth. Indeed, acknowledging vulnerability in relation to a relapse due to a condition's chronicity can either lead to feelings of disappointment and a potential re-traumatisation—because the individual will be preoccupied with searching for a cure (Fortune et al., 2005)—or, as in this study, to feelings of acceptance that can help the individual change negative self-perceptions and develop different and appreciative meanings about life. Therefore, through accepting the chronicity of the psoriasis, the participants of this study challenged their extreme negative views attached to it and made meaning of their

condition, which consequently helped them achieve positive changes in how they view themselves and promoted psychological adjustment.

Construing benefits from a debilitating condition is related to the notion of post-traumatic or adversarial growth, which according to literature it is seen as a springboard for the individual to further develop and achieve positive changes in self-perceptions, personal relationships and philosophy of life (Calhoun & Tedeschi, 1999). Adversarial growth has been studied in the context of suffering, taking the view that patients can benefit or grow as a result of dealing with negative life events such as a chronic disease (Fortune et al., 2005; Sodergren & Hyland, 2000). Fortune et al. (2005) have studied this notion of adversarial growth and, in line with the findings of this study, have found that through CBT the individuals did experience adversarial growth and psoriasis left them positively transformed. Similarly, Eiserman (2001) supports the fact that many people do deal positively with a challenging visible difference and believes that focusing only on pathology (e.g., levels of distress) is unethical. He highly recommends that research should include any benefit finding and positive aspects of living with a difference. This is in line with Counselling Psychology's ethos of moving away from focusing on pathology, symptoms and illness to emphasising strengths, wellness and health (Strawbridge & Woolfe, 2010). An ethos that has an orientation towards empowering clients and facilitating growth as opposed to focusing on symptom-based treatment (Martinelli, 2010; Woolfe, 1996). Consistent with the above, the results of this study reinforce the need for intervention strategies that focus on cognitive procession that contributes to adaptive coping and a self-compassionate approach fostering the individual identify positive consequences of his/her condition.

In closing, it should be recognised that CBT is not a panacea and the theory of Guided Therapeutic Growth provided is not universal. Not all participants were similarly affected by their condition and there was a variation on their experiences of the CBT therapeutic process and on how helpful CBT was perceived by them. Indeed, literature takes the view that psychological distress and therapeutic benefits and growth are multi-factorial with factors such as coping styles (Moss, 1997), self-concept (Moss & Carr, 2004) and general social support (Brewin, MacCarthy, & Furnham, 1989) to be amongst the ones that influence adjustment. Although it is beyond the scope of this study to examine treatment efficacy *per se*, because this study was concerned with exploring processes present in CBT when used as an adjunct to medical treatment for psoriasis, it is worth noting that all participants talked about the therapeutic gains of using CBT as part of the management of their psoriasis. They commented on their therapy as having had a considerable impact on their lives, in terms of helping them make positive changes and reducing anxiety and depression. Most remarkably they reported increased confidence, self-acceptance and self-compassion. There were clear statements from all participants that CBT helped them achieve meaningful changes such as a deeper understanding of self, of their symptoms of psoriasis, of the emotional distress induced by psoriasis and of their needs—a concept that is found to be a key attribute in learning to cope with difference (Bessell, Clarke, Harcourt, Moss, & Rumsey, 2010). Indeed, the importance of self-awareness and self-understanding, has also been documented in literature on disfigurement as an important outcome of treatment (e.g., Bessell et al., 2012). Participants also commented on the improvement of psoriasis severity, but it was hard for them to attribute improvements solely to CBT because they were also receiving medical treatment. However, they did mention reduced flare-ups and associated them to reduced distress as a result of the psychological support.

The theory of Guided Therapeutic Growth does not reflect a standardised approach with rigidly structured interventions that ought to be applied in a strictly linear manner. It proposes four therapeutic factors and suggests how these could be applied in a clinical setting that manages patients with psoriasis. The interrelations and broad sequencing in which the four factors are presented are not meant to be definitive nor to preclude the need for a non-linear approach subject to and based on each patient's individual needs. The initial steps of this model include a period of engaging the patient in therapy early on by helping them understand what CBT is, educating them about the mind-skin link, managing expectations and setting clear therapeutic goals. This is followed by the establishment of a therapeutic relationship that could aid a legitimised self-expression of concerns before specific cognitive interventions are introduced and maladjusted self-schemas and negative thoughts are challenged. As therapy progresses and the therapeutic relationship becomes stronger, the process of disclosure could become less challenging and the patient could feel better able to continue and engage with the cognitive element of CBT. Without drawing quantified conclusions about the level of participants' perceived usefulness of specific techniques and without dictating that the therapeutic findings be applied linearly, this study confirms Clarke's (1999) recommendation that the cognitive work be placed later on in the treatment because it is unlikely to be effective in the absence of feelings of engagement and a positive alliance.

Moreover, the findings of this study take a stance in relation to the interminable debate over relationship versus technique. Seminal authors in psychotherapy and counselling research such as Elliott and Williams (2003) emphasise the importance of relational factors as the main ingredient of change. Indeed, for almost half a century, clients were found to pay little regard to

theory or technique, recognising mostly the importance of the person who is the therapist and the relationship, rather than a particular way of working. Such a standpoint is also consistent with a wealth of psychological findings according to which, non-technical factors have been found to be the most helpful in therapy in ensuring effective change (e.g., Bohart & Tallman, 1999; Elliott & James, 1989; Llewelyn & Hume, 1979; Paulson, Truscott, & Stuart, 1999). Lambert's (1992) study also supported the perception of common factors contributing 30 percent to successful therapy, with only 15 percent attributed to the specific theoretical orientation.

Although the model of this study appears to parallel the argument about the importance of non-specific factors, such as the therapeutic relationship and feelings of engagement in therapy, the results do not justify a definitive conclusion about these factors being the only important ones present in therapy. Rather they suggest that technical elements and components are equally critical and crucial. In other words, non-specific factors are critical and important and aid in engaging and retaining patients with psoriasis in therapy, but they also provide the base for and strengthening of the technical components of the treatment, which are equally crucial. This further suggests that we need to start from the premise that both common relational factors and CBT-specific technical factors, as described by the participants of this study, contribute to psychological change. This model therefore highlights the significance of both technique and relationship. It supports that CBT is an approach based not only on manualised techniques as directed by the therapist, but it is also a relational-oriented approach, which is more process-focused, valuing the therapeutic collaboration and using techniques in a flexible manner (Boucher, 2010). Otherwise, as Hoffart, Borge, Sexton, and Clark (2009) recommend, therapy would stand out as highly decontextualized and mechanical. This way, CBT respects client's

agency and autonomy (Cooper, 2008) and at the same time without blindly abiding by prescriptive, manualised treatment protocols, it gives a “carefully applied push” (Sullivan, Skovholt, & Jennings, 2005, p.60) when needed, adopting a stance of doing with the client instead of doing to or just being with them.

The findings provide evidence of the importance of moving away from imposing inflexible regimes of care and blindly delivering CBT in a dogmatic manner. Instead, it suggests that by engaging the individual in the therapeutic process, building an individualised and non-stigmatising therapeutic relationship, legitimising the expression of patients’ psoriasis-related distress, and flexibly applying CBT interventions that target the dysfunctional meanings attached to psoriasis, the therapist can guide patients with psoriasis towards therapeutic growth. This use of a tailored-CBT approach instead of a “one-size fits all” framework is in line with Counselling Psychology’s values according to which the therapist needs to prioritise clients’ subjective experiencing, appreciate them as unique human beings and commit to a democratic and non-hierarchical client-therapist relationship (Orlans & VanScoyoc, 2008; Woolfe, 1996). Such a framework is of particular significance to individuals with psoriasis whose common experiences include stigma, rejection, negative evaluation and belittling of their concerns, placing a considerable burden on their emotional well-being.

Overall, this study explored patients’ own views of their CBT experience and, through that, identified the active ingredients of change for individuals with psoriasis, and decoded the nature of CBT interventions in more detail. The study confirmed several aspects of the literature and of the recommendations previously made by clinicians with respect to the psychological factors that

enable a psoriasis patient to achieve therapeutic change in a CBT context. Although individual elements of the Guided Therapeutic Growth model can be found in other modalities or can apply when treating other conditions, the study's novelty lies in that the combination and interrelation of all four factors is contextualised and applied specifically to a clinical population with psoriasis receiving CBT.

### **Adopting a Critical View of CBT**

Currently, there is a movement towards promoting Empirically Supported Treatment (EST) and EBP because of the need to advance psychological practice and guide professional decision-making in order to ensure that clients receive the best of what psychology has to offer (Corrie, 2010). This movement has been described as placing great emphasis on and favouring the CBT model for the following reasons: (a) CBT has become such a popular therapeutic approach because it has been applied to a variety of psychological difficulties (Butler, Chapman, Froman, & Beck, 2006; Copper, 2008; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012); (b) it is also the most intensively researched form of psychotherapy because it lends itself more easily to testing (Dryden, 1995); and (c) it has gained the most effective outcomes for a variety of psychological difficulties with quality trials and meta-analytic studies supporting its effectiveness (e.g., Cooper, 2008; Hofmann, & Smits, 2008). As a result, the government has increased the number of CBT-based treatment centres (Hurford & Seward, 2007). Strawbridge and Woolfe (2010), though, describe this emphasis on CBT as unbalanced. Chambless (2002) also suggests that a lack of evidence for less empirically supported treatments does not necessarily mean that there is evidence against a particular form of therapy. One should, therefore, wonder about the reasons behind this wealth of CBT studies supporting its effectiveness and adopt a critical stance. Is it

because CBT is the only modality researchers have really got data on? Does this result in a self-fulfilling prophecy? Is it simply because CBT has had more research for appraisal and review? These interesting points are of pertinence importance issues and have generated heated debates that require our attention.

There are some additional causes for scepticism in relation to CBT. Firstly, patients may not have access to their thoughts and feelings—that they do so is a basic premise of CBT—so it is not a foregone conclusion that they can easily identify the triggers of their psoriasis. Moreover, homework assignment motivation cannot be guaranteed, resulting sometimes in patients' resistance to the therapeutic process (Beutler et al., 2004)—an outcome that has been supported by this study. In addition, because CBT is a time-limited approach, clients may not be able to engage fully in a collaborative relationship within just a few sessions (Young, 1994). Furthermore, CBT uses diagnosis-specific formulations that could allow therapists to predict with some accuracy the kind of emotions, thoughts and behaviours clients are likely to experience. However, there is a danger that these perceptual filters can blind the therapist to the idiosyncratic experiences of clients and lead to inaccurate reflections (Thwaites & Bennett-Levy, 2007). This can be highly contrary to the philosophy of Counselling Psychology, one of the pillars of which is the appreciation of each individual's subjectivity and the understanding of the other person's perceptions *without* imposing preconceived ideas (Woolfe et al., 2003).

Notwithstanding CBT's limitations and criticisms in the literature, the results of this study showed that the participants did perceive CBT as useful and did experience therapeutic benefits and amelioration of their psychological symptoms, albeit to variable degrees.

### **Methodological Considerations**

In order to evaluate the reliability and validity of qualitative findings, a number of methods can be used (Elliott, Fischer, & Rennie, 1999; Reicher, 2000; Smith, 1996). For this study, the criteria proposed by Yardley (2000) were used because these were believed to be sufficiently flexible to account for different methodological approaches, including CGT. These were also found to be consistent with the study's epistemological stance and Counselling Psychology as a discipline.

**Sensitivity to context** is an important criterion. It refers to the research being adequately grounded in related existing literature and theoretical concepts without preventing the researcher from seeking out new findings (Yardley, 2008). In order to account for this criterion, chapter one included the relevant theory and research, the literature gap and the development of the research question; it also provided a valuable framework to enhance researcher's interpretation. Another way to understand this criterion relates to circumstances in which the researcher is an "insider". In this study, although the researcher was not the participants' therapist, she was considered an insider because of her personal and professional experience. These qualities increased her awareness and sensitivity to the topic and helped her to understand participants' constructions of meanings better and deeper. This privileged experience may have enhanced participants' feelings of openness and the honesty of their accounts, because some of them did share what they perceived as less positive experiences of their therapy and less useful interventions, allowing her to gain deeper insights. On the other hand, those qualities may equally have coloured her interpretation of the accounts, leading to limitations, which will be discussed later.

**Commitment and rigour** is another important criterion, according to which the research needs to demonstrate strong engagement with a topic and competence in the research approach. Again here, the researcher's clinical and personal experience of skin conditions has enhanced a deep understanding and engagement with the topic. The researcher has presented a process of analysis that has both depth and insight by giving it full attention throughout, and by following CGT procedures such as constant comparison and memo-writing, the researcher tried to ensure accurate reflection of the participants' experiences to ensure rigorousness. The researcher's success in this regard will be judged by the reader.

**Checking credibility** with the participants or using multiple analysts and triangulation with other sources is another important quality method that ensures rigorousness. The researcher discussed the emergent codes, categories and concepts with her academic supervisor in order to obtain verification through feedback and to confirm the analytic conclusions of the study. Respondent validation was achieved by checking and receiving immediate feedback from participants on the validity of interpretations and meanings throughout the interview process. The use of reflexivity, basic counselling skills, supervision sessions and the technique of constant comparison enhanced this validation. By sharing interpretations based on previous interviews with participants, the researcher was able to explore further whether others shared the same or contrasting views. Furthermore, in order to take into account all data and not just those that fit researcher's perspective, the divergent experiences contradicting the emergent categories were also presented (Henwood & Pidgeon, 1992). This deliberate and articulated search for disconfirming data helped to combat the natural tendency to seek confirmation of preliminary findings. In addition, to help the reader understand better how the theory is developed and to

judge the fit between the data and the analysis, raw data from the interviews have been used, both in the main body of the thesis and in the Appendix M. The researcher thus stayed close to the data by using participants' language to develop codes.

**Transparency and coherence** is another criterion that this study took into consideration. Transparency refers to the demonstration of what has been done and why (Meyrick, 2006). In this study, the researcher tried to describe the research procedures and the design employed in a comprehensive, explicit, and detailed way. This can help the reader to understand the process of the analysis and its appropriateness. A full paper trail, which linked raw data to the final report, has also been used to support the entire process and explain its analytic steps. Details of the sampling techniques and descriptive information about the research participants (Appendix N) ensured quality and may also help the reader to situate the findings within the sample of participants and within the situations in which the study took place. In order to avoid potential bias and ensure quality of data, the researcher kept a reflective diary documenting her personal views and paying close attention to participants' views without assuming an understanding of participants' accounts. Reflexive statements have also been used throughout the report, disclosed in order to help the reader understand how her values, interests, and theoretical orientations may have influenced the analysis of the data. As previously explained, reflexivity is an essential criterion used to enhance quality of the findings (Tracy, 2010) because it enhances transparency. Discussion and feedback from the thesis supervisor were used in order to achieve coherence. Data, analysis, and findings were presented in a coherent way so that the study made sense as a consistent whole. The figure used in chapter three, along with the narrative account explaining

the emergent model, also ensured coherence. It was therefore felt that inferences were logical, plausible, and sufficiently grounded in the data.

The last important point that a researcher needs to consider in order to produce valid research is the **impact and importance** of the study. Yardley (2000) suggests that research needs to offer a new way of understanding the topic and to have an impact on society and culture. Charmaz (2006) includes originality as a criterion and suggests that new insights need to be provided that can extend or refine the previous literature. This study has offered a meaningful way of understanding the factors that contribute to the outcome of CBT for participants with psoriasis, moving away from a medically positivist way of exploring it. It generated a model of CBT factors present in the psychological management of psoriasis that can better inform clinicians about what individuals experience as more or less helpful and what they need from therapy. A better understanding of patients' perceptions will enhance clinical practice and practitioners will potentially be more aware of and sensitive to the processes present in therapy. Such an enhanced awareness and sensitivity derived from the results of this study could have a significant impact on the field. Overall, observance of the above criteria means that the study conformed to good qualitative practice and ensured that the emergent model was grounded in the data.

### **Limitations**

The researcher's dual occupational position in the process, as a trainee Counselling Psychologist in the Psychodermatology department, needs to be acknowledged. Yardley (2000) suggests that a power imbalance between researcher and participants may lead to participants restricting their responses. The researcher recognises that although her training position as Counselling

Psychologist at the Dermatology Department has possibly facilitated the interview process and has helped in the pursuit of greater depth in some areas, the participants may have changed their accounts to avoid sounding too critical, due to the possibility of seeing the researcher in the future in the department. Alternatively, they may have felt obliged to portray therapy in more positive terms than they would have done otherwise. Therefore, it could be hypothesised that interviews conducted by someone from another trust may have possibly produced different accounts. Moreover, attention needs to be given to the fact that all participants volunteered to participate in the study. Volunteers may differ from a broader sample in their motivation to be involved, which may affect the nature of the findings (Rozmovits & Ziebland, 2004). This may have shaped the results differently, because volunteers usually have either a particularly positive or extremely negative experience. This factor is difficult to control or be certain about, but the differing accounts and the overall experiences described from participants of this study provided some reassurance about the nature of the findings.

A further limitation of this study is the fact that it relied on retrospective accounts, which could be subject to bias (Elliott, 1986) because participants may have forgotten what was really going on. Although the researcher recognise this limitation, it could also be suggested that asking patients to think back over the whole course of therapy has given this study a more pragmatic, holistic, and significant impression of what a client has taken away from the therapy in the longer run.

### **Implications**

The emergent model has a variety of implications for clinical practice, research, and training.

The results of this study hold implications for what has been described as an alternative psychotherapy paradigm, namely, the PBE paradigm (Castonguay, 2011). PBE refers to non-experimental research by practitioners in naturalistic or routine clinical settings. The resulting theory of this study gave a sense of the reality of routine practice and showed how CBT works in an uncontrolled setting without limiting or controlling variables. This adds to the argument made for a complimentary approach to building an evidence base that is rooted in routine practice (Charman & Barkham, 2005). By providing evidence based on practice, suggestions and recommendations based on what the participants of this study perceived as useful can be put forward and can improve therapeutic decision-making. In particular, a greater understanding of what has been perceived as useful from this group of individuals from their psychological treatment of psoriasis could sensitise therapists to clients' internal and covert processes. This could provide some direction to guide therapists and help them develop an understanding of specific processes of the moment-to-moment therapeutic dialogue between themselves and their clients.

In line with the PBE paradigm, this study recommends avoiding treating the results as strict guidelines upon which we firmly base a prescriptive practice derived from controlled findings. Instead, it recommends that the truth presented here is not a single, universal, and lasting one, but one among many (Charmaz, 2003). Thus, the findings of this study are not intended to transport a manualised treatment into practice; rather, they aim to portray that these are not *the* way to practice therapy for individuals with psoriasis but rather *a* way, based on the accounts of the nine participants of this study. Therefore, the knowledge created from this study could be used in a way that will not dismiss clients' real needs and views of world but instead will enhance clients'

well-being by using the findings as evidence to educate practitioners about moment-to-moment decision-making based on reflections on the context and the relationship. This is in line with Counselling Psychology's stance, which emphasises subjectivity, looks beyond guidelines, and accommodates the protocols to fit the client's needs and not vice versa.

The results of this study could further influence counselling training programmes. It has been advised that a major emphasis needs to be placed on enabling the students to learn how "to be" with their clients and constantly move their focus from the "doing to" to the "being with", because the latter is still difficult to master (Sanders, 2010). However, the results of this study suggest that the focus of the training of future therapists needs to be placed equally on the notions of "being with" and "doing *with*", and that trainees need to learn how to simultaneously and continuously offer both of these states to their patients. Given that a wide variety of individuals are being trained in CBT in much greater numbers than in any other formal psychotherapy approach previously (Thwaites & Bennett-Levy, 2007), training programmes really need to consider both of these states and not just focus on "doing to".

This study also has implications for the place of CBT within the discipline of Counselling Psychology. The counselling world has not readily embraced CBT for its more technical aspects, which concentrate on the methods and not on the process of therapy (Sanders & Wills, 2005). This study's findings can be used as a platform to challenge these attitudes that regard CBT as not giving enough attention to the relational factors, because what was evident from the study was the importance of these factors alongside the use of a range of powerful tools to provide a positive therapeutic experience as perceived by the participants. This could raise awareness

among Counselling Psychologists and contribute to the increasing attractiveness of CBT within Counselling Psychology for that reason. It also adds to the argument that CBT is an evolving approach, which means that it fits with the ethos of contemporary Counselling Psychology (Sanders, 2010).

The findings of this study can add to the existing literature in (psycho)dermatology, where typically a medical ethos of care is adopted and individual's experiences about the psychological impact of the therapy have often been ignored. The study's findings could therefore increase awareness by shedding light on the patients' experiences and views regarding the psychological management of psoriasis. This related to Counselling Psychology's nature of this study that places emphasis on working over and above notions of diagnosis and treatment (Division of Counselling Psychology, 2001), on the subjective experience, and on its critique of the tyranny of the medical model (Strawbridge & Woolfe, 2003). Clinicians could thus be better educated about the value of individuals' needs and, as a result, patients would receive more understanding because the delivery of treatment would also reflect decisions informed by the participants' perceptions of factors impacting their treatment. Improved therapeutic formulations will enhance the clinical management of psoriasis. A therapeutic atmosphere wherein core needs are being met will be promoted, providing the context for therapeutic benefits change to take place. This informed guidance could also be the basis for facilitating the provision of psychological support services and provide further evidence for the ways CBT interventions can be applied for the successful and more holistic management of psoriasis because there is little scope within our present health system for psychological interventions for individuals with skin conditions (British Association of Dermatologists); only 4% of dermatology units in the UK provide a

dedicated counselling service (Bewley et al., 2012). The results of this study can ensure that the delivery of treatment reflects decisions informed by the participants' perceptions of factors impacting their treatment. Considering the prospects of increasing demands for cost-effective care (Department of Health, 1997), such practice might result in decreased use of health care services, inappropriate referrals and might be a viable financial proposition, as in studies of cancer patients' provision of support (Simpson, Carlson, & Trew, 2001).

### **Directions for Future Research**

This study could be viewed as a starting point from which further research can be conducted. Future research may study the outcomes of CBT as experienced by both clients and therapists. It is possible that the inclusion of therapists' views would enrich and supplement data and we would gain insights into clinical practice from both viewpoints. Moreover, interviews with participants reflecting a wider range of age, psoriasis severity, and psychological distress would help establish the degree to which this model might be transferable to a greater number of individuals along the wider spectrum of psoriasis and distress severity. In addition, considering that the relationship with other clinicians appears to be a significant factor for individuals with psoriasis, it seems valuable to explore the findings of this study with Counselling and Clinical Psychologists and other healthcare professionals in order to understand this topic from a variety of viewpoints and to explore how it is viewed and how it is practiced. Such research would add value to the existing understanding of CBT for psoriasis and would help clinicians to provide treatment collaboratively.

Moreover, beliefs that patients with psoriasis hold about their condition and medication are pertinent and influence adherence to treatment. Adherence to medication is associated with different beliefs about the skin condition (Byer & Myers, 2000). Research supports the view that the effectiveness of treatment depends on motivational levels on taking care of the skin (Fortune et al., 2002). It would be therefore interesting to investigate individuals' experiences of treatment who are less motivated or who do not adhere to treatment.

Lastly, it has been suggested that the complementarity between experimental and non-experimental protocols means that together they can form the optimum research, which is both rigorous and relevant (Barkham & Mellor-Clark, 2000). Experimental designs could therefore be employed to test the emergent theory of this study across different health boards and test whether the views observed would remain applicable and could be replicated and statistically supported for larger samples. The results of such a future study could be added to the argument that views both EBP and PBE paradigms as a cyclical model in which each feeds into the other in order to generate robust knowledge (Barkham & Barker, 2003). This complementarity is suggested to have important implications for the relationship between policy, practice, and research. In this cyclical model, practitioners could develop and build evidence rooted in practice, which could then feed into and inform issues and hypotheses that could be tested through efficacy research such as RCTs (Barkham & Mellor-Clark, 2003), yielding policy products informed by a combined evidence base.

### **Concluding and Reflecting Thoughts**

As the research moved towards completion, I found myself revisiting the model of Guided Therapeutic Growth and reflecting on my identity as a practitioner. This process helped me appreciate the value and therapeutic importance of the study's findings for the psychological management of psoriasis and helped me understand the need to focus on particular interventions for this group. For instance, I have always valued the importance of establishing a positive therapeutic relationship. However, now I came to understand on a more granular level the significance of its multiple constituent parts. It was the sense of collaboration, non-judgemental attitude and understanding clinical team that made this relationship unique and valuable. Additionally, I appreciated even more the importance of not just giving these individuals the space to express their distress, but also ensuring that they do not feel vain or bad for doing so. This is significant because psoriasis truly is not "just a skin condition" and has many ways of "scarring" an individual. I understood the significance of the legitimisation process more deeply and became more aware of how it influences the therapeutic experience and contradicts feelings of rejection, judgement and invalidation. Additionally, I came to understand in more detail the impact of particular cognitive interventions on the therapeutic experience. I realised how important is for patients with psoriasis the concept of working with cognitions in relation to control and of facilitating a grieving process when addressing perceptions of a lost former self/appearance.

Most importantly, due to the variety of the participants' accounts on their experiences of their treatment, I came to appreciate the individuality and complexity of each patient. This has enhanced my focus on delivering treatment plans and offering therapy in relation to their

particular needs ensuring that these are addressed in a therapeutic context that abides by Counselling Psychology's pluralistic and integrative approach to practice and emphasises the integration and acceptance of difference.

In addition, I came to appreciate the value of the qualitative paradigm for providing some answers and reassurance despite its uncertainty. This paradigm has highlighted the complexity and diversity of individual participants, as observed within the data. In particular, the nature of CGT has proven invaluable in providing the base for the multiplicity of perspectives among participants to manifest themselves. As a researcher, this experience has highlighted to me the importance of fluidity, flexibility, and evolution that CGT offers. I found it non-constraining and non-rigid. It helped me transform my passion, interest, and curiosity for my work into knowledge that could be applied. It gave me the freedom and flexibility to go back and forth between research steps and helped me understand the local context in which the phenomenon occurred. It helped me tolerate ambiguity and trust the process when I was wondering if my analysis had value or when I was uncertain about how the final picture will look like. The challenging realisation of the fact that results cannot fit neatly together and that there is no right or wrong answer made me feel uncomfortable. CGT's structured approach gave me grounding and guidelines and helped me realise that the (only) truth that matters is a co-constructed one between participants and the researcher. As a result, it actually provided me with a high level of trust in the process.

Revisiting the results of this study has been a challenging but also an invaluable learning process for me. Retrospectively, though, I understand the meaning of what Glaser calls a "delayed

action”, in that important findings sometimes emerge after one has lived with the data for a while.

In conclusion, reflecting on the process of this journey, I found it enjoyable, albeit challenging at times, but above all, it was an empowering experience that led to an enhanced understanding of CBT contributions to the psychological management of psoriasis. It is hoped that this information will supplement not only my own but also other practitioners’ professional practice and that it might be the basis for developing new approaches within the therapeutic treatment at dermatology services, thus linking research to practice.

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## **Appendices**

### **Appendix A**

#### **Search Strategy for literature review**

The literature on this topic has been searched using a methodological approach, which has involved techniques such as scanning, skimming and mapping (Machi & McEvoy, 2012). The scanning of library and online catalogues, periodical indexes and abstracts, was helpful in identifying useful work relevant to the reviewed topic. Papers were selected according to relevance and date of publication. Specialist databases that were searched included: PsycInfo, Science Direct, Medline, EBSCO, and Google Scholar. As a research method, the snowballing technique was employed whereby referenced articles cited in the initial reading material were pursued, thereby expanding the search and extending the scope of the researcher's reading (Ridley, 2008). Search terms included: "psychodermatology", "skin diseases", "therapeutic/psychological interventions", "psoriasis", "CBT", "effectiveness". A Boolean query connected the key words by the logical operators "and", "or" and "not" in order to frame the database search. Manual searches were also carried out in London Metropolitan University library and the Senate House library. An extensive literature search was also conducted through Counselling Psychology Journals such as the Counselling Psychology Review and the Journal of Counseling Psychology. The titles and the abstracts were initially reviewed. For those that were found relevant to the research topic a second review was conducted which included manual review of the full text. At present, no literature has been found to identify the factors that contribute to the outcome of CBT for individuals with psoriasis.

## Appendix B

## Confirmation of Ethical Approval from London Metropolitan University

**Professional Doctorate in Counselling Psychology**  
**Study outline and ethics application: Supervisors Report**


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**Title of study:** Understanding the factors that contribute to the outcome of Cognitive Behavioural Therapy for individuals with psoriasis: A Qualitative Study

**Student name:** Marietta Laoudi

**Student number:** 09025357

**Supervisors:** Samantha Farag

Please indicate your judgement of the type of project and the ethics classification in I and II below.

**I. Type of Project [CIRCLE one alternative for each of (i) and (ii)]**

- (i) Vulnerable Population
- (ii) Non-Controversial Topic

**II. Ethics classification [CIRCLE A, B or C]**

**A** The ethics submission form is complete\*. No, or merely routine, ethics issues are raised and the proposal addresses all of these adequately.

**B** The ethics submission form is complete\*. Controversial ethics issues are raised , although the proposal resolves these adequately.

**C** The ethics submission form is complete\*. Controversial ethics issues are raised , yet these are not resolved adequately by the proposal.

\* as defined by the panel's specification of content. If it is not the form should be returned to the student for completion **prior** to submission to the panel.

**Where supervisors give a classification of C**, please specify the problem(s), and if appropriate, offer guidance to the Ethics Panel from your area of expertise.

**Supervisor's signature:** S.Farag

**Date:**11.01.12

## Appendix C

## Confirmation of Ethical Approval Letter from NHS National Research Ethics Service

  
**Health Research Authority**  
**NRES Committee East of England - Norfolk**  
 Nottingham REC Centre  
 The Old Chapel  
 Royal Standard Place  
 Nottingham  
 NG1 6FS

Telephone: 0115 8639436

13 January 2014

Ms Marietta Laoudi  
 145 Finborough Road  
 SW10 9AW

Dear Ms Laoudi

<b>Study title:</b>	<b>Understanding the factors that contribute to the long-term outcome of Cognitive Behavioural Therapy in psoriasis: A qualitative study</b>
<b>REC reference:</b>	<b>13/EE/0416</b>
<b>IRAS project ID:</b>	<b>111119</b>

Thank you for your letter of 10<sup>th</sup> January 2014, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Ms Tracy Leavesley, NRESCommittee.EastofEngland-Norfolk@nhs.net.

#### **Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

#### **Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

*Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett ([catherineblewett@nhs.net](mailto:catherineblewett@nhs.net)), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

**You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.**

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

### Approved documents

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of insurance or indemnity	Gallagher Health	06 September 2013
Interview Schedules/Topic Guides	2.0	13 January 2014
Investigator CV	Dr Alexandra Mizara	
Other: CV	Marietta Laoudi	
Other: CV	Sandra McBride	
Other: CV	Samantha Farag	
Other: Debriefing Information Sheet	1.0	05 November 2013
Other: Debriefing Information Sheet (people not participating)	1.0	08 January 2014
Participant Consent Form	1.0	05 November 2013
Participant Information Sheet	2.0	08 January 2014
Protocol	2.0	08 January 2014
REC application	111119/517289/1/58	15 October 2013
Response to Request for Further Information	Email from Marietta Laoudi	10 January 2014

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

#### Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

#### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

<b>13/EE/0416</b>	<b>Please quote this number on all correspondence</b>
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We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



**Elizabeth Lund**  
**Alternate Vice Chair**

Email: NRESCommittee.EastofEngland-Norfolk@nhs.net

Enclosures: *"After ethical review – guidance for researchers"*

Copy to: *Ms Marietta Laoudi*

*Stuart Jones, Royal Free London NHS Foundation Trust*

Appendix D  
Participant Information Sheet

**Version: 2.0**  
**08/01/2014**

**Dermatology Department**  
**Royal Free Hospital**

Pond Street  
London  
NW3 2QG

[www.royalfree.nhs.uk](http://www.royalfree.nhs.uk)  
Switchboard: 020 7794 0500  
Fax: 020 7830 2468  
Direct line: 0207 830 2351

## Participant Information Sheet

Study Title: Cognitive Behavioral Therapy (CBT) for psoriasis: Understanding the long-term impact of CBT in psoriasis.

*You are being invited to participate in a research study. Before you decide whether you would like to take part or not, it is important to understand what this research is about and what it will involve. Please take time to read the following information carefully and if you wish, you may also want to discuss this with other people. If you are unclear about any information or you require more details regarding this study, please feel free to contact either me or my supervisor (contact details are provided below). Please take your time in deciding whether you would like to take part in this study or not.*

### What is the research about?

This study is part of a Professional course in Counselling Psychology. The aim of this study is to explore the experiences of patients with psoriasis who have undergone CBT treatment. You will have an opportunity to have discussions about your views and experiences of CBT. My aim is to understand your view and your experience and to see whether or not there are any differences or similarities with other participants. It is hoped that through this study Counselling Psychologists and other healthcare clinicians will gain more knowledge on how individuals with psoriasis view this type of treatment. This improved understanding will help them provide more effective therapy for future patients.

### Why have I been approached?

You are being approached because you are an adult who has psoriasis and has had a completed course of CBT as part of the wider treatment of your skin condition. Therefore your views on your experience are very important.

### Do I have to take part in the study?

It is entirely up to you to decide whether or not to take part and please do not feel under any pressure to participate. If you do decide to take part you will be asked to sign a consent form. If you decide to take

part you are still free to withdraw from the study without giving any reason. Withdrawing from the study will not have any adverse implications for you or for any future treatment you may require.

#### What happens if I decide to participate in the study?

If you are happy to participate in this study you will be asked to complete and sign a consent form. The Chief Investigator, Marietta Laoudi, will contact you to make arrangements for a time that is convenient for you to meet with her. If you wish, you can also contact her directly. You will be asked to visit her at Royal Free Hospital. You will have a conversation that will last approximately 45-60 minutes where you will be invited to discuss your experience of CBT. You will get reimbursed for your travel expenses (travelling to and from the location of the interview). You will be asked to provide a receipt of your travel.

#### Will anyone know what we have discussed?

All information gathered will be treated with strict confidentiality. You will remain completely anonymous (i.e., your name and identity will not be made available and will be kept separate from the findings of the interview). The only person who will have access to this information will be the Chief Investigator, Marietta Laoudi. All information will be secured and locked in a safe place and later (in five years' time) will be destroyed. Everything said during the conversation will remain confidential, however confidentiality will be breached if your information disclosed suggests any illegal activity (such as drug trafficking) or/and harm to self or others. In this case, appropriate services- authorities will be contacted.

The conversation will be tape recorded, transcribed and then segments may be used in the study. The academic supervisors will have access to the anonymous transcripts of your interview. Your participation in this study and the content of your conversation will not be discussed with other interviewees. Throughout the study you will be identified only as a number.

#### What will happen to the results of this study?

The findings of this study will be used in a thesis. The findings will be disseminated in a journal. Anonymity and confidentiality will still be in place. You can get a summary of the findings if you are interested.

#### Are there any adverse effects when taking part?

None are anticipated. However, in order to ensure that your well-being is safeguarded at all times, measures will be taken to minimize the risk of distress. These include taking a break or even stopping the interview if you find the research and the conversation to be very distressing. You have the right not to answer any questions if you do not wish to do so. After the interview, you will be able to ask any questions or discuss any issues related to the study. You will be provided contact details for further support.

#### Comments or concerns

If you have any concern about this study, please feel free to contact the Chief Investigator Marietta Laoudi. Otherwise, you may wish to contact the Research Supervisor Dr Esther Murray, through London Metropolitan University (E.Murray@londonmet.ac.uk).

Your contribution to the study

Your input will be much appreciated as you will contribute to the understanding of CBT for psoriasis and therefore through your experience, Counselling Psychologists and healthcare professionals will be able to provide more effective therapy to patients with psoriasis. You might also appreciate the opportunity to talk openly and share your experience about CBT.

*Thank you for taking the time to read this information sheet*

Marietta Laoudi

[mar.laoudi@gmail.com](mailto:mar.laoudi@gmail.com)

Tel: 0759 9702 315 Counselling Psychologist Trainee Royal Free Hospital, Pond Street, Clinic 6, London, NW3 2QG

Appendix E  
Consent Form

**Version: 1.0**  
**05/11/2013**

**Dermatology Department**  
**Royal Free Hospital**  
Pond Street  
London  
NW3 2QG

www.royalfree.nhs.uk  
Switchboard: 020 7794 0500  
Fax: 020 7830 2468  
Direct line: 0207 830 2351

Patient ID:

CONSENT FORM

**Research Title:** CBT for Psoriasis: Understanding the long-term impact of CBT in psoriasis

**Researcher:** Marietta Laoudi

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Y/ N

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.

Y/ N

3. I also understand that in the debriefing at the end of my participation I will be provided more details of the present study and I will have any opportunity to make any queries regarding this study.

Y/ N

4. I understand that the information in this study will be strictly confidential, it will be only looked at by the research team and I will not be identifiable in any report of this study. However, I also understand that there are limits to confidentiality, where the researcher has to breach confidentiality if the information disclosed is for example illegal or likely to cause harm to self or others.

Y/ N

5. I understand that data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information.

Y/ N

6. I give consent to audiotaping my conversation and to allow the researcher use verbatim quotations in the write-up or publication of the study. I understand that I will be given a pseudonym in any written material so that my identity will not be revealed.

Y/ N

7. I understand that I may be contacted in the future by the researcher so as to provide feedback about interpretations.

Y/ N

8. I have been given information with the researcher's name on and a contact number and address if I require further information.

Y/ N

9. I agree to take part in the above study.

Y/ N

NAME OF PARTICIPANT: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

*Thank you*

#### INVESTIGATOR'S STATEMENT

I have informed the above participant of the nature and purposes of this study and have sought to answer any questions to the best of my ability. I have read, understood, and agree to abide by the Ethical Principles for Conducting Research with Human Subjects set out by the British Psychological Society in carrying out this study.

RESEARCHER'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Appendix F  
Participant Debrief Sheet

**Version: 2.0**  
**17/10/2014**

**Dermatology Department**  
**Royal Free Hospital**  
Pond Street  
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www.royalfree.nhs.uk  
Switchboard: 020 7794 0500  
Fax: 020 7830 2468  
Direct line: 0207 830 2351

### DEBRIEFING INFORMATION SHEET

Title: CBT for Psoriasis: Understanding the long-term impact of CBT in psoriasis.

Thank you very much for making this study possible. Your help is much appreciated. This sheet is an opportunity for you to understand more about this study.

This study aims to explore how people with psoriasis experience and understand the CBT model of treatment. I was also interested in your understating of CBT and how do you feel about having had this type of treatment. It was also of interest to explore what did you find more or less effective in your CBT treatment. In particular, I was interested to know which type of intervention was more/less useful for you. Finally, I was interested to know how did you find the relationship with your therapist and if relational factors (such as trust, motivation for change) or your therapist's qualities could possibly have had an effect on the result of treatment.

Existing literature suggests that CBT can be effective for managing the distressing symptoms of psoriasis, it is not yet clear what makes CBT an effective treatment. Research also shows that CBT techniques in general can be effective but some interventions are more effective and helpful than others. What is more, increasing evidence on the importance of the relationship between the client and the therapist, may suggest that this factor might have an impact on the treatment outcome. However, there is no literature so far in providing us with answers to these questions. Therefore, your experience and your participation in this study has shed light on this type of treatment and psoriasis and will help practitioners understand better what individuals with psoriasis want from their psychological treatment. A more effective treatment can then be provided to patients with psoriasis.

If answering any of these questions has resulted in you feeling distressed or upset and you would like to speak to someone about your thoughts and concerns, I have provided below a list of supporting services.

### Sources of comfort and help

- Barts and the London NHS Trust:  
The London Skin Centre that offers support to people with psoriasis.  
StBartholomew's Hospital (Barts)  
West Smithfield London EC1A 7BE, The Royal London Hospital  
Whitechapel London E1 1BB, tel: 020 7377 7427,  
[www.bartsandthelondon.nhs.uk/our-services/skin-centre](http://www.bartsandthelondon.nhs.uk/our-services/skin-centre)
  
- The Royal Free Hospital  
Psychodermatology department that offers support to people with skin disorders.  
Pond Street, NW3 2QG, tel: 020 7472 6197,  
[www.royalfree.nhs.uk/pip\\_admin/docs/psychoderm](http://www.royalfree.nhs.uk/pip_admin/docs/psychoderm)
  
- The Samaritans is a 24 hours helpline provides support to people in distress.  
Helpline number: 08457 909 090; [www.samaritans.org](http://www.samaritans.org)
  
- Psoriasis Association is a UK based charity dedicated to representing the needs and supporting the needs of people of any age with any type of psoriasis. Their website provides essential information to the unique needs of people with psoriasis and offers support through their forum and chat room;  
[www.psoriasis-association.org.uk](http://www.psoriasis-association.org.uk)
  
- British Psychological Society. Provides details regarding qualified psychologists trained in a variety of methods.  
St Andrews House 48, Princess Road East, Leicester LE1 7DR, tel: 0116 227 1314, [www.bps.org.uk](http://www.bps.org.uk).

If you are interested in the results of the study, or if you have any questions about this study please contact the researcher on the following email address: [mar.laoudi@gmail.com](mailto:mar.laoudi@gmail.com). Alternatively you can give me your postal address and I will send one copy of the results when the research is finished.

If you have any complaints regarding any aspect of the study or anything regarding the research that you do not wish to share with me please email my supervisor; Dr Esther Murray: [E.Murray@londonmet.ac.uk](mailto:E.Murray@londonmet.ac.uk)

Your contribution to this research study is very valuable and greatly appreciated.

*Thank you very much for your participation.*

## Appendix G

## Debriefing Information Sheet for Individuals Not Participating in the Study

**Dermatology Department  
Royal Free Hospital**Pond Street  
London  
NW3 2QGwww.royalfree.nhs.uk  
Switchboard: 020 7794 0500  
Fax: 020 7830 2468  
Direct line: 020830 2351**Version: 2.0  
17/10/2014****DEBRIEFING INFORMATION SHEET**

Title: CBT for Psoriasis: Understanding the long-term impact of CBT in psoriasis.

Thank you very much for your interest in participating in this study.

Unfortunately you were not selected for this study. This will not have any impact on your management and care.

This study aimed to explore how people with psoriasis experience and understand the CBT model of treatment. It was also of interest to explore what did you find effective or less effective in your CBT treatment. Finally, we were interested to know whether relational factors (such as trust, motivation for change) or your therapist's qualities could possibly have had an impact on the result of treatment.

Existing literature suggests that CBT can be effective for managing the distressing symptoms of psoriasis. However, it is not yet clear as to what makes CBT an effective treatment for people with psoriasis. There is no literature so far in providing us with answers to these questions and the research has tried to shed more light on psychological intervention for people psoriasis.

If you would like more information about this study (i.e., results of the study) or you would like to voice any feedback, please let us know either by e-mailing the researcher on the following email address: [mar.laoudi@gmail.com](mailto:mar.laoudi@gmail.com) or by discussing this with your clinician.

If you have any complaints regarding any aspect of the study or anything regarding the research that you do not wish to share with me please email my supervisor; Dr Esther Murray: [e.murray@londonmet.ac.uk](mailto:e.murray@londonmet.ac.uk).

*Thank you very much.*

Appendix H  
Distress Protocol

## **DISTRESS PROTOCOL**

### **Protocol to follow if participants become distressed during participation:**

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their interview on their experience of CBT. There is a possibility for participants to still experience some degree of psychological difficulty.

The researcher is undergoing professional training in Counselling Psychology and has experience in managing situations in which distress occurs. It is not expected that extreme distress will occur, or that the relevant action will become necessary, because full attempt will be made at the initial stages of recruitment to ensure that potential participants are not in an acute and vulnerable psychological state and their readiness to talk about their experiences of CBT will be assessed. Their suitability will be verified in the form of an introductory telephone conversation with potential participants in order to minimise any risks.

Should participants become distressed and/or agitated, a three step protocol is provided below that gives details of signs of distress that the researcher will look out for, as well as actions to take at each stage.

### **Mild distress:**

#### **Signs to look out for:**

- 1) Tearfulness
- 2) Voice becomes choked with emotion/ difficulty speaking
- 3) Participant becomes distracted/ restless
- 4) Pace of speech becomes slower and tone of speech becomes lower

#### **Action to take:**

- 1) Express concern and ask participant if they are happy to continue
- 2) Offer them the time to pause and compose themselves
- 3) Remind them that they can stop at any time they wish if they become too distressed

- 4) Determine if the person is experiencing emotional distress beyond what would be normally expected in an interview about a sensitive topic area

### **Severe distress:**

#### **Signs to look out for:**

- 1) Uncontrolled crying/ wailing, incoherent speech
- 2) Panic/anxiety attack- hyperventilation, shaking, fear of impending heart attack
- 3) Indications of flashbacks
- 4) Participant demonstrating extreme difficulties with concentration/attention owing to above

#### **Action to take:**

- 1) The researcher will intervene to terminate the interview
- 2) The debrief will begin immediately
- 3) Suggest relaxation techniques to regulate breathing/ reduce agitation
- 4) Assess mental status and ask participant what are they feeling at the moment and what thoughts are crossing their mind
- 5) The researcher will recognise participants' distress, and reassure them that their experiences are normal reactions to expressing personal experiences and that most people recover from such psychological distress.
- 6) Ask the participant if they would like to speak to a friend or a member of family (e.g., over the phone) to help reassure them
- 7) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss this further with mental health professionals and remind participants that the interview is not designed as a therapeutic interaction
- 8) Details of available counselling/therapeutic services will be offered to participants (Appendix 5)

### **Extreme distress:**

#### **Signs to look out for:**

- 1) Severe emotional distress such as uncontrolled crying/wailing
- 2) Severe agitation and possible verbal or physical aggression
- 3) In very extreme cases- suicidal ideation and plans expressed/possible psychotic breakdown

#### **Action to take:**

- 1) Maintain safety of participant and researcher
- 2) If the researcher has concerns for the participant's or others' safety, she will inform them that she has a duty to inform the appropriate mental health services, such as their GP.
- 3) If the researcher believes that either the participant or someone else is in immediate danger, then she will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
- 4) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain them and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency).

Appendix I  
Interview Schedule - Stage 1

**Interview questions**

Researcher's role: Welcoming the participant and reviewing the information sheet

Asking participant to sign the consent form

Reminding participants of the importance of confidentiality and cases of breaching it

Starting the interview with warm-up questions

1) Tell me about what happened and you came to decide that CBT would be worth trying?

Prompts/ Probes:

- What was going in your life at that time?
- What, if anything, did you know about CBT?
- What, if any, were your expectations from CBT?
- How have you arrived at this view?

2) Can you tell me about your experience of CBT?

Prompts/ Probes:

- What was it like?
- How would you describe a CBT session?
- What did it involve?

3) What, if anything, have you found helpful? Less Helpful?

Prompts/ Probes:

- What has contributed to this view?
- Could you give me an example?

4) Can you tell me about your therapist?

Prompts/ Probes:

- What was your experience with your therapist like?
- What has your therapist's role been?

5) What, if at all, changes have occurred in your psoriasis?

Prompts/ Probes:

- What has contributed to this change, if any?
- What impact, if any, has this had on your skin condition?

- How have you experienced these changes, if any?
  - How do you understand this process to have happened?
- 6) Is there anything that you might not have thought about before that occurred to you during this interview?

Prompts/ Probes:

- As you look back on the period when you had CBT, can you think of anything missing from CBT?
- After having this experience, what advice would you give to someone who is about to start CBT?
- Is there anything else that I have failed to ask you and you feel you would like to share?
- What was it like to talk about the CBT that you had?

Researcher's role (at the end of the interview): Thanking the participant for coming and debriefing time

Asking participant if they have any questions

Signposting participants to contacts for support

Appendix J  
Interview Schedule - Stage 2

**Interview questions**

Researcher's role: Welcoming the participant and reviewing the information sheet

Asking participant to sign the consent form

Reminding participants of the importance of confidentiality and cases of breaching it

Starting the interview with warm-up questions

1) Tell me about what happened and you came to decide that CBT would be worth trying?

Prompts/ Probes:

- What was going in your life at that time?
- What, if anything, did you know about CBT?
- What, if any, were your expectations from CBT?
- How have you arrived at this view?

2) Can you tell me about your experience of CBT?

Prompts/ Probes:

- What was it like?
- How would you describe a CBT session?
- What did it involve?

3) What, if anything, have you found helpful? Less Helpful?

Prompts/ Probes:

- What has contributed to this view?
- Could you give me an example?

4) What was your experience of homework?

Prompts/ Probes:

- What did it involve?
- How did the process feel like?
- What did this experience mean to you?
- What was the purpose of homework from your point of view?

5) Can you tell me about your experience of talking?

Prompts/ Probes:

- What was it like for you?
- What, if anything, have you found important in the process of talking?
- What was different, if at all, about the process of talking to your therapist?
- How have you arrived at this view?

6) Can you tell me about your therapist?

Prompts/ Probes:

- What was your experience with your therapist like?
- What has your therapist's role been?

7) What therapist's qualities, if any, have been more/less helpful to you?

Prompts/ Probes:

- What impact, if at all, has your therapist had on any therapeutic change?

8) What role, if any, had other clinicians played in your decision to start therapy?

- How have they influenced you view of therapy?
- What, if anything, have the clinicians contributed to your experience of CBT?

9) What, if at all, changes have occurred in your psoriasis?

Prompts/ Probes:

- What has contributed to this change, if any?
- What impact, if any, has this had on your skin condition?
- How have you experienced these changes, if any?
- How do you understand this process to have happened?
- Which areas, if any, in your life have been influenced by this change?

10) How would you compare the person you were before and the person you see yourself as now?

Prompts/ Probes:

- Who or what, if anything, has been influential in this change?
- Which aspects of the therapy experience (process) have you found to be influential in your view of yourself and/or psoriasis?

11) Is there anything that you might not have thought about before that occurred to you during this interview?

Prompts/ Probes:

- As you look back on the period when you had CBT, can you think of anything missing from CBT?
- After having this experience, what advice would you give to someone who is about to start CBT?
- Is there anything else that I have failed to ask you and you feel you would like to share?
- What was it like to talk about the CBT that you had?

Appendix K  
Interview Schedule - Stage 3

**Interview questions**

Researcher's role: Welcoming the participant and reviewing the information sheet

Asking participant to sign the consent form

Reminding participants of the importance of confidentiality and cases of breaching it

Starting the interview with warm-up questions

1) Tell me about what happened and you came to decide that CBT would be worth trying?

Prompts/ Probes:

- What was going in your life at that time?
- What, if anything, did you know about CBT?
- What, if any, were your expectations from CBT?
- How have you arrived at this view?

2) Can you tell me about your experience of CBT?

Prompts/ Probes:

- What was it like?
- How would you describe a CBT session?
- What did it involve?

3) What, if anything, have you found helpful? Less Helpful?

Prompts/ Probes:

- What has contributed to this view?
- Could you give me an example?

4) What was your experience of homework?

Prompts/ Probes:

- What did it involve?
- How did the process feel like?
- What did this experience mean to you?
- What was the purpose of homework from your point of view?
- What role has it played in the process of the therapeutic change, if any?
- How, if at all, has it helped you towards achieving progress?

- In your opinion, what impact, if any, has homework had on your behavior?
- How has this made you think/feel about yourself and psoriasis?

5) Can you tell me about your experience of talking?

Prompts/ Probes:

- What was it like for you?
- What, if anything, have you found important in the process of talking?
- What was different, if at all, about the process of talking to your therapist?
- How have you arrived at this view?
- What role has your therapist had in the process of therapeutic talking?
- How, if at all, has your therapist influenced the process of therapeutic talking?
- How have you arrived at this view?

6) Can you tell me about your therapist?

Prompts/ Probes:

- What was your experience with your therapist like?
- What has your therapist's role been?

7) What therapist's qualities, if any, have been more/less helpful to you?

Prompts/ Probes:

- What impact, if at all, has your therapist had on any therapeutic change?
- How, if at all, has your therapist influenced the way you view yourself and psoriasis?
- To what degree, if at all, did you feel helped by your therapist?

8) What role, if any, had other clinicians played in your decision to start therapy?

- How have they influenced you view of therapy?
- What, if anything, have the clinicians contributed to your experience of CBT?

9) How, if at all, has the cognitive element of CBT been for you?

- How do you understand this?
- What did this experience mean to you?

- What impact, if any, did thinking have on any change?
- How, if at all, did you view yourself and/or your psoriasis differently?

10) What, if at all, changes have occurred in your psoriasis?

Prompts/ Probes:

- What has contributed to this change, if any?
- What impact, if any, has this had on your skin condition?
- How have you experienced these changes, if any?
- How do you understand this process to have happened?
- Which areas, if any, in your life have been influenced by this change?

11) How would you compare the person you were before and the person you see yourself as now?

Prompts/ Probes:

- Who or what, if anything, has been influential in this change?
- Which aspects of the therapy experience (process) have you found to be influential in your view of yourself and/or psoriasis?

12) Is there anything that you might not have thought about before that occurred to you during this interview?

Prompts/ Probes:

- As you look back on the period when you had CBT, can you think of anything missing from CBT?
- After having this experience, what advice would you give to someone who is about to start CBT?
- Is there anything else that I have failed to ask you and you feel you would like to share?
- What was it like to talk about the CBT that you had?

## Appendix L

## List of Open Codes, Followed by Focused and Theoretical Coding

This source is an illustration only and more participants than the ones included in this sample have talked about the same topics.

<b>Open coding</b>	<b>Focused coding</b>	<b>Theoretical coding</b>	<b>Participant</b>
Losing control of work, life, skin, everything. Regaining sense of control by knowing what to do- having a toolkit of things. Feeling reassured, hopeful and proactive	Perceived loss of control	Cognitive restructuring of meanings attached to psoriasis	Claire (Line 620-637)
Feeling listened to, being given the permission to share views about relationship. Feeling mutual to therapist and working together. Non-hierarchical therapist-patient relationship	Non-judgemental and collaborative nature of relationship	Trusting Therapeutic Relationship	Allen (Line 319-335)
Empathetic therapist towards client's distress. Empathetically directing patient to challenge negative cognitions. Patient feeling comfortable	Levels of directiveness in relation to moment-to-moment attunement to needs. Empathically directive	Trusting Therapeutic Relationship	Emily (Line 312-334)
Appreciating doctors' help. Not feeling alone fighting the world anymore. Supported by the clinical team. Feeling grateful and helped- wanting to participate in the present study	Relationship with the dermatology team	Trusting Therapeutic Relationship	Martin (Line 180-186, 704-709)
Not just focusing on psoriasis, Identifying predisposing and perpetuating factors related to psoriasis	Inter-related factors influencing psoriasis	Legitimising self-expression of distress associated with psoriasis	Stephanie (Line 592-602)

## Appendix M: Interview Excerpts

An example of several verbatim transcripts illustrating line-by-line, focused and theoretical coding through the process of constant comparison.

<u>THEORETICAL CODING</u>	<u>FOCUSED CODING</u>	<u>LINE BY LINE CODING</u>	
<p>Legitimising the expression of distress</p>	<p>Having appearance-related concerns not dismissed by therapist</p>	<p>Having someone who listens when feeling upset Hard to explain to others impact of psoriasis</p> <p>Others not understanding and underestimating impact of psoriasis- Belittling Feeling as if “vain/ superficial”</p> <p>Contrasting experience of talking to therapist with talking to family Talking to an understanding therapist who did not dismiss emotional pain. Feeling reassured and comforted by therapist. Being in a therapeutic place when concerns are not dismissed. Having distress expression normalised.</p> <p>Expressing feelings. Not having to be brave, not</p>	<p>Claire</p> <p>71. I<sup>7</sup>: Right... um... so now focusing and exploring a bit 72. more your experience of CBT and the whole process of 73. that, what was it like for you? [...]</p> <p>91. Claire: I think it was just about having somebody 92. who would listen to me, because with something like 93. psoriasis it's very hard to explain to people what an 94. effect it's having on you. They just see “Oh it's a bit of 95. itchy skin”, you know.. It is very hard to explain to 96. people, because you feel like you are being vain, you.. 97. it's like I don't want to wear the clothes that I like and I 98. don't feel like I look nice. It just sounds like it's very 99. superficial. So actually having somebody to talk to who 100. said no, that's absolutely valid, it's fine, like don't 101. worry about it, was um that was in the beginning was 102. sort of reassuring I guess, and comforting that you 103. know, what I was telling was seemingly fairly 104. common among people who had psoriasis and before 105. that I didn't really know anyone who had psoriasis 106. apart from my auntie and my auntie she was a very 107. stoic, you know northern woman... “Oh just put some 108. cream on it”.</p> <p>109. I: Uh huh</p> <p>110. Claire: I don't want to put some cream on it... I want to 111. wear nice clothes (smiles).. So in the beginning it was just 112. having somebody who I could kind of ... be upset with</p>

<sup>7</sup> I: Interviewer

<p>associated  with  psoriasis    Feeling  engaged  with therapy   process</p>	<p>Patient's attitudes towards homework</p>	<p>suppressing distress in relation to perceived severity Being self and permission to moan  Others belittling impact of psoriasis Not treating it as serious- Lack of understanding          Having the opportunity to read case studies. Personal time to reflect Using homework as self-reflection Homework facilitating development of reflective skills. On-going self-reflections, not only during therapy Adopting reflective stance between sessions  Encouraging use of homework Appreciating its benefits  Homework connecting/ gluing sessions Reading/thinking/reflecting Understanding self</p>	<p>113. because you are supposed to be sort of brave in front of 114. everyone, aren't you, you're not supposed to sort of 115. moan...it's only a bit of flaky skin, you know, other 116. people have cancer! Okay? That's why people don't treat 117. it as something serious because it's not life 118. threatening...and it's, you know, it's not going to kill you.  [...]  533. It was giving me the opportunity to go away from 534. here with things like the case studies and, you know, 535. to go and bit of just like a reflection time on my own 536. rather than just focusing everything on being: ok this is 537. the one hour of the week where I think about myself, 538. you know giving me just.. 539. I: time to reflect on.. 540. Claire: yeah.. and I think you know that definitely is 541. something I would say if people would ..if people are 542. going to do this is good to encourage people to have a 543. bit of homework..you know.. I think otherwise it's very 544. easy to just isolate the experience to what happens in 545. this room and not really take it away with you..so I 546. found things like reading and thinking about, you know 547. some of the handouts she gave me..  [...]</p>
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<p>Cognitive restructuring of meaning attached to psoriasis</p>	<p>Modifying maladaptive appearance-related schemas</p>	<p>Keeping an open mind</p> <p>Start thinking about own thoughts Evaluating situations differently</p> <p>Less catastrophic thinking Less rigid views of self/ more flexible thinking Not automatic negative thinking More inclined to think positively about self</p> <p>Adopting self-compassionate. Less self-critical.</p> <p>Thinking retrospectively</p> <p>Giving self the space and time to think and reflect before reaching conclusions. More pragmatic and realistic thinking</p> <p>Opening up options</p>	<p>Stephanie</p> <p>563. <b>I:</b> How would you compare yourself and where you were</p> <p>564. and how you see yourself now, these</p> <p>565. days</p> <p>566. Stephanie: Well yeah, I think what it did do to</p> <p>567. me... I was aware (emphasis) of cognitive</p> <p>568. therapy, but I had never subjected</p> <p>569. myself or been you know subjected to</p> <p>570. cognitive therapy work, so... Ehm.. I</p> <p>571. think it did open that up a bit for me,</p> <p>572. to start thinking, well is this a good</p> <p>573. thing or a bad thing. Maybe, before I</p> <p>574. would say oh it's definitely a bad</p> <p>575. thing. And now... I'm a little bit more</p> <p>576. inclined to think first, well, is it a good</p> <p>577. thing? Maybe... You know. Sorry, by</p> <p>578. default I tend to label certain things.</p> <p>579. That's definitely a bad thing. Ehm, now</p> <p>580. some days I might think "Is it a bad</p> <p>581. thing or is it a good thing? Time will</p> <p>582. tell." And then I look back and quite</p> <p>583. often I think I would say "that wasn't</p> <p>584. so bad", you know it might have</p> <p>585. looked it at the time, but actually...</p> <p>586. with a bit of distance ... um perhaps it</p> <p>587. was a good thing.</p> <p>588. <b>I:</b> Uh huh</p> <p>589. Stephanie: So it opens up options, I think.</p> <p>[...]</p>
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<p>Establishing an Idiosyncratic Therapeutic Relationship</p>	<p>Non-judgemental therapeutic relationship</p> <p>Maintaining suitable levels of directiveness (empathic directiveness/attunement)</p>	<p>Therapist not judgemental</p> <p>Easy to talk to therapist Feeling comfortable expressing distress Being in a sympathetic environment with an empathic therapist</p> <p>Feeling appropriately challenged by an assertive yet sympathetic therapist- benefiting from this process Challenging/directing her "as much as needed"</p> <p>Feeling comfortable with therapist/relationship/environment.</p> <p>Describing therapist as a pillar.</p> <p>Therapist challenging in a supportive, gentle, empathic way.</p> <p>Moment-to-moment attunement</p> <p>Therapist offering empathy Encouraging self-expression.</p>	<p>Emily</p> <p>310. <b>I:</b> How did you experience her?</p> <p>311. You said she was helpful, she was listening...</p> <p>312. Emily: Yeah, I think ehmm.. I think [my therapist] is not</p> <p>313. judgmental. So, I mean I don't know if a</p> <p>314. psychologist should be judgmental, I don't</p> <p>315. think so (smiles) but, definitely didn't have that</p> <p>316. kind of attitude. So, it was very, very easy to</p> <p>317. talk to. But at the same time, especially in my</p> <p>318. time when I was quite distressed, she was quite</p> <p>319. sympathetic. Obviously, she was challenging</p> <p>320. me, you know, to..to..if I was saying something negative</p> <p>321. and she would say "Why?" or whatever, so she was</p> <p>322. assertive but yet very sympathetic. So, it was</p> <p>323. really, really pleasant at least, you know, I don't</p> <p>324. feel uncomfortable at all, yeah. If not, I actually</p> <p>325. at that time I was looking forward to coming</p> <p>326. here because I really, I could see the benefit of</p> <p>327. it. So ehmm.. for the time when I was coming</p> <p>328. here she was, in a way, you know, a pillar for</p> <p>329. me, you know.</p> <p>330. <b>I:</b> Right. So, even though she was challenging</p> <p>331. you, you said that she did that in a gentle way?</p> <p>332. Emily: Yeah, yes.</p> <p>333. <b>I:</b> In a supporting way?</p> <p>334. Emily: Absolutely. [...]</p> <p>348. Emily: She was empathic...</p> <p>349. yeah, and she was, she was very, what's the</p> <p>350. right word, you know, she was..ehmm..</p> <p>351. encouraging me to, you know, to, to express it</p> <p>352. or whatever the emotion was at that time, you</p> <p>353. know, to express it.</p>
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Appendix N  
Participants' Demographic Details with Pseudonyms

	Steven	Stephanie	Lily	Claire	Allen	Emily	Martin	Becky	Tom
<b>Age</b>	65	54	38	45	51	41	48	57	42
<b>Gender</b>	M	F	F	F	M	F	M	F	M
<b>Location of psoriasis</b>	Scalp, forehead, legs	Scalp, forehead, ears, legs	Scalp, forehead, patches on body mainly legs	Legs, scalp, elbows, hands	Lower back, back of legs	Face, knees, breast	Elbows, knees, hands	Elbows, knees	Scalp, forehead, elbows, knees
<b>Age of onset of psoriasis</b>	16	6	32	40	26	14	23	54	12
<b>Medication</b>	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Length of therapy</b>	7 sessions	8 sessions	12 sessions	12 sessions	6 sessions	12 sessions	12 sessions	12 sessions	6 sessions
<b>Presenting problem</b>	Depression. Obesity, low self-esteem	Depression	Anxiety	Anxiety	Depression, anxiety, alcohol abuse	Depression, Obesity	Depression, Social Anxiety	Depression, Anxiety, Panic Attac	Anxiety

PASI Mean Score: 4.5(Pre) 4.0(Post) Anxiety: 11.1(Pre) 5.0(Post) Depression: 7.5(Pre) 4.7(Post)

## Appendix O

### Example of Memo

The purpose of this memo is to try and clarify a few thoughts on the process of talking because I found that participants referred to this process as an effective element within their therapeutic experience. Subsequently, I wanted to explore what talking is like for them and began to ask questions to further unpack and unravel this process.

Participants speak specifically of their ability to express themselves and to offload their distress. They talk a lot about feelings of relief and a sense of understanding one's self better. But how does this actually occur? What makes "talking" so important for them?

As I continue with the interviews, I find that participants speak specifically about talking to a professional rather to a friend or family member. They make a clear distinction between these two audiences and emphasise the importance of therapeutic talking compared to informal conversations. It appears that this distinction mirrors the different feelings the participants experience between people who help them feel understood and are empathetic of what they are going through and those who do not and belittle their distress. This possibly implies that participants might have had a less supportive experience when trying to communicate to others their emotional concerns. Participants' accounts further suggest that although they were trying to talk to family and friends about distressing feelings, at the same time they were trying to protect them. I guess coming to therapy and experiencing this "special type of talking" to a therapist, it has been a unique experience for them. But what makes it happen? How easy/difficult is it for participants to express themselves? I feel that within the therapeutic setting, they could talk about their emotional pain, express themselves and offload their distress without having to protect anyone.

Interestingly, I noticed that for some participants talking has also been a challenging experience as they expressed mixed feelings about it. From their accounts, it seemed that it could also hinder engagement with the therapeutic process. This is an interesting paradox that I need to check out with future participants. What factors may have led to this happening? What is the therapeutic relationship's role in this paradox? Is there a difference between genders? Do women find it easier to talk? I need to make sure I interview an equal number of males and females. Did the participants who found talking as a challenging process engage well in therapy? Did they not experience the therapeutic relationship as a positive one? So far, it appears that participants speak highly of the therapy alliance and have had a positive experience of it. However, these questions still remain unanswered. What about their views of their therapist? How significant is the role of the therapist in the process of talking? I need to explore this further and understand how therapists can facilitate or hinder talking, if at all.

Revisiting this category, I realise that the term "talking" is too abstract and does not capture the complexity of my findings. I need to clarify the more granular concepts that this word is meant to represent. A more representative terminology would be "expression of distress around psoriasis."

To ensure I have fully captured what the participants shared with me, I also need to go back to the original data and review my coding process. It is now clear that my previous generic term of "talking" does not clearly reflect the much more special and particular experience of this study's participants, which involves the sense of legitimising their psoriasis-related distress and exploring the factors that trigger their flare-ups. In other words, it isn't just the process of expressing themselves (i.e. "talking")... it is a much more meaningful, non-burdening and non-dismissing experience. It is a very powerful element of their CBT treatment because it allows them to be upset about psoriasis without feeling dismissed. It helps them understand that their

experience is normal and common among people with psoriasis and that they should not hide their emotions, even the ones who found the process challenging and were initially reserved.

I'm also noticing that several participants discuss non-psoriasis topics during therapy. This makes sense, since psoriasis can be triggered by a number of external stressors. So it's important to see how these external factors come into play during the CBT.