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Integrated Cognitive Behavior Therapy: Implications for Professional Identity. A Systematic Review

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ABSTRACT
A systematic literature of thirty-nine full text publications ranging between 2000-2021 was conducted and analysed utilizing a narrative synthesis. The review was interested in the implications of bespoke psychological therapy for comorbid psychological and physical health conditions, particularly with NHS Talking Therapies in mind. The review sought to address research questions regarding the operationalisation of integrated therapy and the implication for professional identity of psychological therapists who work in collaborative settings. Findings were applied to NHS Talking Therapies who have publicly created a specialized pathway in primary care to treat clients with comorbid conditions. It was found that most healthcare providers were enthusiastic about integrated therapy but that semantic tangling impacted on deployment. Therapist training is often uniprofessional, helpful for professional identity formation but when entering interprofessional networks identity risks included blurred role boundaries and resorting to case management allocation rather than fostering creativity, thereby underusing the skills within the integrated network. Recommendations were made to provide frequent reflexive practice both within and between professionals with feedback.

KEYWORDS: NHS Talking Therapies; interprofessional identity; integrated therapy; long-term health conditions; systematic review

There is "no health without mental health" according to a governmental policy document in the United Kingdom (HM Government, 2011, p.1). Those living with long-term health conditions and medically unexplained symptom (LTC/MUS), disorders which cannot be cured but can be managed, are at least twice as likely to meet diagnostic criteria for common mental health disorders (Department of Health, 2008), with 12-18% of NHS expenditure associated with managing the interaction between psychological and physical health (Naylor et al., 2012). The Mental Health Taskforce (2016) identified that those with LTC/MUS are more likely to develop complications if their mental health was not also addressed, thus a recommendation was made to integrate a bespoke "integrated pathway" into primary care mental health services as part of the NHS Talking Therapies programme. The NHS Talking Therapies programme is an ambitious mental health model of primary care service delivery designed to treat common mental health disorders including depression, anxiety disorders, and post-traumatic stress disorder (PTSD). It is distinct as a mental health programme for its dedication to evidence-based clinical interventions, most commonly Cognitive Behavioral Therapy (CBT), outcome monitoring and supervision. Treatment interventions are tailored to the needs of clients by offering different levels of treatment from low intensity guided self-help

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provided by psychological wellbeing practitioner (PWPs) to high intensity CBT treatments provided by high intensity psychological therapists (HIs).

NHS Talking Therapies continues to adapt in response to the needs of their clinical population. In 2018, informed by the publication of the Five Year Forward View, NHS Talking Therapies published their intention to develop specialist pathways for clients who had comorbid LTC/MUS (NHS England & NHS Improvement, 2018). It was thought that a significant proportion of clients with LTC/MUS may benefit from increased targeted access to psychological therapy leading to a trial of early implementer sites, following which the majority of NHS Talking Therapies services have adopted the model. The key changes to routine practice are that some therapists are relocated within physical healthcare settings and receive a significant proportion of their signposting/referrals from physical health professionals in contrast to the traditional GP or self-referral route. Therapists receive specialist training to learn about common long-term health conditions which initially focussed on obesity, Chronic Obstructive Pulmonary Disease (COPD) and diabetes before expanding to a wide range of LTC/MUS. Therapists were provided with a lengthy and thorough course of training regarding adaptations of CBT for clients with LTC/MUS (e.g. Furze et al., 2008; Naylor et al., 2012) alongside enhanced supervision with health psychologists (Wroe et al., 2015). Terminology has adapted to reflect the creation of the specialist pathways whereby therapists located in the new LTC/MUS treatment pathways are referred to as working in integrated services to differentiate from Core NHS Talking Therapies (NHS Digital, 2018).

Prior to the creation of the integrated pathway, an analysis of a large group of patients in primary care with depression or anxiety disorders (n=28,498) found that those with LTC/MUS were more likely to require High Intensity CBT interventions, yet lead to lower recovery rates (Delgadillo et al., 2014). The early implementer sites such as those in the South West of England, however, found in a service evaluation study an almost equitable recovery rate of 52% for the integrated pathway compared to 54% in the Core pathway (Wilkins et al., 2018), both of which are above the national target at the time of 50% (NHS Digital, 2020).

Although psychological therapists will always have seen clients who also have physical health needs, the integrated pathway formalized this with innovative systemic changes and enhanced training. Integrated therapy in this regard means enhancing "the whole team's capability to provide more comprehensive, accessible and holistic services…identifying the person's needs more quickly and accurately…" to include "…a single jointly developed care plan [which] can lead to improved relationships within teams and services" (National Collaborating Centre for Mental Health, 2019, p.16). In terms of collaborative working, the implementation guidance includes the following principles: clearly defined local pathways and referral facilitation between psychological and physical health services, proving a timely service, working proactively between teams and "taking a collaborative approach to care planning" which means developing a care plan that is developed and shared with the patient and all those in their care with a named person responsible (National Collaborating Centre for Mental Health, 2019, p.28).

The focus of this review is the impact of this policy shift for professional identity of therapists specialising as part of the integrated pathway who both operate in a novel therapeutic collaboration and utilize an increasingly diverse range of therapeutic competences. Professional identity is considered to be the intersection between professional and personal values in the application of psychotherapeutic practice (Dollarhide et al., 2023). Transition theory suggests professional identity development is not as linear as first hypothesized (Kralik et al., 2006). The most significant professional identity transition points appear to be the extent of the structural and ideological shift of one's working environment, power (Suddaby et al, 2007) and retaining a sense of skill and alignment with organisational values. Ibarra (2004) believes identity can be consciously moulded during transition junctures by reflectively sifting through possible iterations of oneself to ask "who do I want to be?" and adapting behaviors accordingly, a

process of "struggling" and "aligning" (Reissner & Armitage-Chan, 2024). Career Construction Theory further argues that the professional self is always in flux (Savickas, 2013), with the risks of emotional disengagement a greater risk during significant transition points (Browne & Collett, 2023).

Although CBT has been shown to be effectively adapted for many long-term conditions, the experience of therapists implementing the integrated pathways is varied, and is not yet considered sufficient to address the range of needs of clients (Martin et al., 2022; Scott, 2025). Rimes et al. (2014) reported therapists were largely optimistic about integrated working, however many rely more heavily on training to improve their self-efficacy (Hamilton-Westa et al., 2018) which retains a uniprofessional stance to complexity, an effect stronger still when treating clients with medically unexplained symptoms (Salkovskis et al., 2016). Much prior research has tended to focus on the transition from trainee to qualified status, therefore this literature review sought to investigate the impact of specialism through the following research questions:

- Research question 1: How do psychotherapists understand collaborative working with clients who have comorbid LTC/MUS in primary care?
- Research question 2: What are the key professional identity transformational junctures for psychological therapists?
- Research question 3: How do multiprofessional contextual factors affect therapists' professional identity?

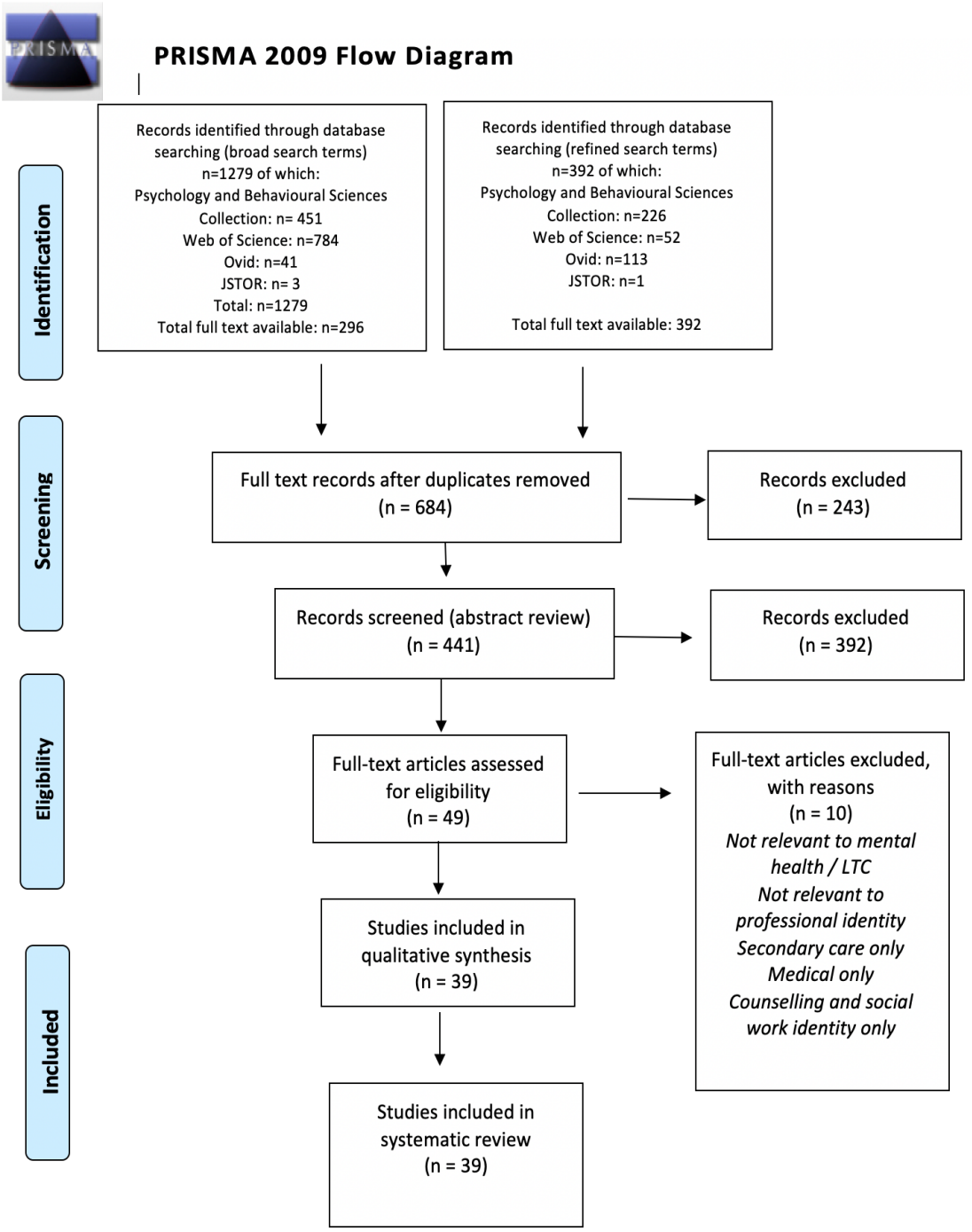
Methods

The databases Journal Storage (JSTOR), Psychological and Behavioural Sciences Collection, Web of Science, PsychINFO (Ovid) and PubMed were searched for peer reviewed articles ranging from 2000-2021. This date range was selected to include significant milestones in service transition including the beginning of the NHS Talking Therapies programme in 2008 and the integrated pathway. Key words used the search included professional identity, collaboration, psychological therapy and LTC/MUS including truncation and orthographic variations.

The search strategy retained articles related to professionals offering mental health care to adults with LTC/MUS in primary care settings, and professionals who would likely signpost into primary care or work alongside allied health professionals. Studies were not included if there was insufficient evidence of psychological practice, a greater focus on secondary or tertiary care, and where outcomes related solely to educational environments. Studies were evaluated using the Critical Appraisal Skills Programme (CASP) frameworks recommended for data synthesis and literature reviews (Majid & Vanstone, 2018). Studies which scored higher on CASP evidence steps taken to improve trustworthiness and data transparency.

A total of 1,671 potentially suitable articles was identified. Duplicates and articles without full texts available were discounted and the abstracts of the remaining 441 titles were reviewed against the inclusion criteria. The articles included a wider spectrum of professions and therapy orientations than originally envisaged. A decision was made to retain articles for full text analysis where it was likely the results could be applicable to professional identity formation and challenges in interprofessional teams for primary care therapists working with comorbid LTC/MUS and common mental health diagnoses treated within NHS Talking Therapies services. Of the remaining 49 articles, 10 were excluded after full text review as they either recruited solely medical participants, had little to no reference to LTC/MUS, were substantially secondary care focused or focused on counselling/social work identities only which are not likely to be representative of NHS Talking Therapies services. Thus, a total of 39 articles were retained and analysed as a narrative synthesis.

Figure 1
Data Synthesis

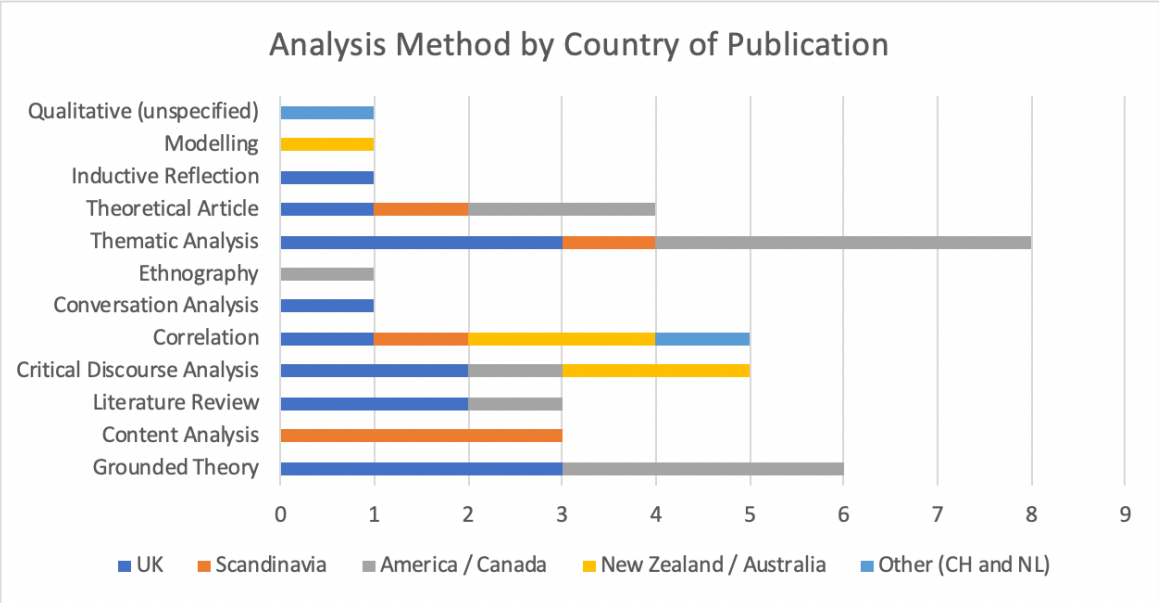


Results

Thirty-nine publications were retained for full text analysis. The largest proportion of studies were published in the UK which is not a surprising finding as search terms containing IAPT or NHS Talking Therapies were likely to preference UK studies as the only country adopting the NHS Talking Therapies programme. The majority of papers favoured qualitative methodologies (67%) when researching professional identity, of which 31% used Thematic Analysis, 23% Grounded Theory, 19% Discourse Analysis, 12% Content Analysis, 8% were reflective or unspecified, 3.5% Conversation Analysis and 3.5% used Ethnography. There were, however, some useful articles which had attempted to quantify key identity and personality

factors (Mitchell et al., 2011; Molleman & Broekhuis, 2012; Porter & Wilton, 2019; Scanlon, 2018), the latter two of which selected the Professional Identity Questionnaire (PIQ) (Brown et al., 1986) in their studies. The PIQ is a validated measure initially treated with scepticism by field experts, but which has fared well in more recent subsequent studies of its validity and reliability (Toben et al., 2021). A further quantitative study (Mitchell et al., 2011) utilised the PIQ and other validated measures of professional identity, including ruptures and conflicts that can occur when professional identity is threatened, yet highlighting the benefits to team identity with heterogenous members.

Figure 2
Study granularity



- Research question 1: How do psychotherapists understand collaborative working with clients who have comorbid LTC/MUS in primary care?

Semantic Tangling

Integrated therapy was rarely explicitly defined. A clearer definition is provided by Ambrose-Miller and Ashcroft (2016, p.101) who consider that "integrated models bring various healthcare providers together…provide team-based case…in the most appropriate and efficient manner (with a goal to) improve health outcomes).

The concept of efficiency is echoed by Mitchell et al. (2011) who extend the definition to include that integrated working should contribute to clinical decision making through streamlined care pathways. The aim, they write, is to reduce duplication and subsequent costs in health economic terms. The authors add that integrated teams are assumed to "generate broad knowledge when compared with more homogenous teams (Mitchell et al., 2011, p.1324). The Integrated Pathway relies both on successful promotion and suitable referrals. The sometimes fractious relationships clients with MUS may have with their GPs was noted by Balabanovic and Hayton (2019) who suggest that clients may resist a psychological explanation of their difficulties. They add three functions therapists engaged in integrated therapy should consider: to improve the means of access, to build a strong therapeutic connection with the client, and to engage in change processes which include supporting the client to connect meaningfully with both the physical and psychological aspects of their condition with all those involved in their care. Mitchell et al. (2011) note that much is assumed about the positivity of integrated working

but few studies were able to quantify or specify such factors which was a research gap they sought to address. The authors found a positive relationship between "openness" defined as willingness to learn from other professions, and team identity (β=.64, t=7.00, p<0.001) and an inverse relationship between openness and identity threat in tertiary healthcare teams. They concluded that integrated working could yield mutually beneficial results for individuals and teams but only when team identity was strong.

A discourse analysis of data from online forums of students discussing inter-agency and interprofessional working and service users (Reynolds, 2007) also challenged the assumption that integrated working was entirely positive. They found that overly positive representations of increased collaboration leading to a seamless journey often led to a portrayal of roadblocks in care pathways for patients and power struggles between teams. Rose and Norwich (2014) agree that integrated working is often beset by challenges but they do not consider this problematic. Rather, they find that resolving dilemmas is part of negotiating how teams can complement one another's roles for the benefit of their clients. Focusing on organisational restructuring in children's services, the authors write that interprofessional conflict is part of navigating towards a common goal provided there is reciprocal respect.

The extent to which the findings above are able to provide a useful conceptualisation of integrated therapy suitable for NHS Talking Therapies remains under question however. It is problematic to compare NHS Talking Therapies with secondary and tertiary care where "care teams" as defined by Ambrose-Miller and Ashcroft (2016) and Mitchell et al. (2011) may be more akin to care co-ordination for those with severe and enduring psychological illness or highly complex physical health needs which would not map neatly onto NHS Talking Therapies patient cohorts. Two papers were identified as particularly relevant for therapists working with co-morbid physical health needs, and provide a useful comparison. Hammarberg et al. (2019) interviewed GPs in Scandinavia about their experience of working with "care managers" who were often specialist nurses trained to co-ordinate psychological and physical healthcare needs for clients with LTC/MUS. Luca (2012) interviewed psychological therapists in the NHS about their experience of working with clients who have MUS.

Hammarberg et al. (2019) found that GPs were concerned about role definition/boundaries and the challenges of changing working practices. However, GPs felt that a care manager provided "structure and standardisation" (Hammarberg et al., 2019, p.278) such that depression could be more effectively managed alongside physical healthcare needs. Luca's (2012) interviews sought to define what cognitive behavioral activities and interventions were most helpful to link physical and psychological factors to shed light on the nature of integrated working. They found that collaboration related first and foremost to the therapist and client reaching a mutual, formulated understanding of their difficulties. Collaborative therapy, they suggest, includes the therapist and client agreeing together when and how to bring in another professional's skill. The role for *multi-disciplinary co-operation* was then sought to gain an alternative perspective by combining medical and psychological knowledge with the therapist adopting a care management role. This paper appears to be one of the first to write about integrated therapy as a set of targeted competencies selectively actioned through client/therapist collaboration as opposed to inter-department liaison.

The semantic tangling around integrated working may, however, be deliberate in some cases and shed light on aspects of professional identity. Kvarnström (2008) considers integrated practice as a continuum in which prefixes such as inter, trans or multi in relation to professional integration are related to the level of interaction and responsibility between professions. When responding to critical incidents in professional practice the authors found that respondents preferentially used some terms synonymously yet avoided others. For example, all participants conceptualised their teams as "interprofessional" or "transprofessional" but did not identify as "multiprofessional." This was hypothesised to relate to perceptions of who held managerial responsibility. Terminology use however was considered not to affect team effectiveness as all

participants "regarded their teams as having mainly patient treatment tasks" (Kvarnström, 2008, p.195). This could suggest that the way in which healthcare professionals conceptualise integrated working may influence team dynamics and that varying terminology may not be problematic in all cases.

The review of literature related to this research question has found that there is ambiguity in defining integrated therapy. In some cases, the definition of integrated therapy appears to be more applicable to whole teams learning to work together or seeking advice between departments (Ambrose-Miller & Ashcroft, 2016; Gumus et al., 2019; Mitchell et al., 2011; Reynolds, 2007). In cases where integrated therapy referred to specific therapeutic competencies and behaviors terms such as "integrated," "multi-disciplinary," "collaborative" and "care manager" are used interchangeably yet seem to relate to different activities and practices (Kvarnström, 2008). The way in which terminology is used may therefore provide insight into values, behaviors, responsibility and power dynamics. These findings are consistent with a recent literature review of healthcare terminology (Flores-Sandoval et al., 2021) which found that ambiguity in healthcare terminology can lead to misunderstandings and difficulties in operationalising effective working practices. Together this suggests integrated therapy is poorly understood.

- Research question 2: What are the key professional identity transformational junctures for psychological therapists?

Professional Identity formation: Training

Training was found to be a key juncture in professional identity formulation. In a study of academic professionals, the journey from *student* to *professor* did not solely involve knowledge or skill acquisition, but also individuals recounted *perceiving the fit* of their organisation or specialism alongside their own values (Sweitzer, 2009). This finding was replicated equally in healthcare professional cohorts (Gazzola et al., 2011). This effect was particularly strong towards the end of a period of study when transitioning from student status to embodying the qualities of the occupation in question (Holmesland et al., 2010; Jongho-Park & Schallert, 2019). Training seemed to provide both the acquisition of skill but also involves internalising and aligning the organisational values with one's own (Bentley et al., 2017; Jakobsen et al., 2011).

The idea of *being professional* was deconstructed by Jongho-Park and Schallert (2019) whose participants subdivided professionalism into tasks such as problem-solving, reflexivity and collaboration skills. Education and counselling psychologists according to this study valued learning discipline-specific language and discursive practices later in their training. Interestingly, a study comparing n=428 occupational therapy, physiotherapy and nursing trainees with a cohort of alumni (Jakobsen et al., 2011) found that identity factors shift in terms of importance throughout the educational process. Students rated clinical skill development (uniprofessionalism) as the most important factor, secondly the ability to collaborate (interprofessionalism), thirdly professional identity development and lastly honing technical competencies. However, the alumni cohort significantly increased the importance given to professional identity compared to the students (χ^2=20.53, p<0.001), placing professional identity as the most important factor when transitioning from training to qualified practice. The authors suggest that knowledge acquisition becomes less important with experience, yet professional identity is strengthened through the interaction with other colleagues and contexts. In this way, the authors hypothesize a positive relationship between professional identity and collaboration.

During training role models were found to be important. Gazzola et al. (2011) interviewed ten counselling psychology doctoral students finding that role models/mentors increased a sense of belonging to a profession and thereby internalising organisational values

which contributes to "an emerging sense of expertness" (p.261). Mellin et al. (2011) found that a recurring theme for counsellors was that those who struggle with their professional identity tended to cite power dynamics as an influential factor. Power imbalance led to internalized negative perceptions of their profession and feeling undervalued. Counsellors in the study noted that ambiguous definitions impede development of a cohesive identity. The term "counselling," for example, is often used as a short-hand for any kind of psychological therapy which seems to negate role defining characteristics.

Counsellors in Mellin et al.'s study reported that when a profession is not as well established temporally it is challenging for individual professionals to view how their identity aligns alongside existing structures. This is all the more challenging, they suggest, when the organisational values are defined with only broad criteria such as "wellness" and "prevention." These terms were considered difficult to operationalize, teach and evaluate and thus it was challenging for counsellors to internalize the core role functions. This effect is considerably stronger when counsellors specialize.

These findings are consistent with those from another qualitative study, Bentley et al. (2019), who interviewed twenty-two PhD candidates about their future career perceptions. The resulting model, Scaffolding Identity Construction, suggested that professional identity is composed of multiple interlinking component "selves" which comprise: direct observation (*doing model*), seeking advice from a trusted peer (*guidance model*) and crucially in the context of integrated therapy, a role model who embodies valued traits (*being model*). Access to multiple aspects of the professional self allows people to conceptualize themselves in contrast from their colleagues, and interestingly in the context of scaffolding these devices were also utilized to differentiate the current identity from previous incarnations. In this case, psychological practitioners with physical health backgrounds shaped their discourse around factors central to the new identity. These factors included how to use specialist terminology and learning to talk, think, and relate to others as a representative of the chosen profession (Schubert et al., 2021; Wade, 2016).

It is possible, as Bentley et al. (2019) point out, that qualitative research with students or newly qualified professionals may be influenced by a desire to tell one's story in a way which is inspirational to other trainees, and the recency effect may increase the perceived importance of training to professional identity development. Yet studies which recruited professionals who had been in practice for much longer agreed that training was a significant formative experience for identity (Ambrose-Miller & Ashcroft, 2016; Luca, 2012). Studies which recruited qualified professionals however found other factors to be formative such as adherence to NICE guidelines (Court et al., 2017), accrediting bodies (Hemsley, 2013) and contextual factors. The next section considers the impact of such organisational infrastructure factors.

Accrediting Bodies

Psychological Therapists in NHS Talking Therapies must be affiliated with an accrediting body such as the British Association of Behavioral and Cognitive Psychotherapists (BABCP) and adhere to the NICE guidelines. No studies recruited NHS Talking Therapies CBT Therapists, however studies which recruited exclusively or mostly from psychologists were considered to be closely linked to NHS Talking Therapies practice and would likely share a similar accreditation requirement. A quantitative study testing the measurement properties of the PIQ theorized a possible correlation between the strength of professional identity and adherence to the evidence base (Scanlan, 2018). Indeed, several authors foregrounded the competence to fulfil role expectation in the definition of professional identity (Baker & Lattuca, 2010), however for many this is not considered sufficient (Court et al., 2017; Hemsley, 2013; Smart et al., 2018).

Court et al. (2017) interviewed clinical psychologists about their beliefs about, and use of, the NICE guidelines in their practice. For some, the guidelines were used informatively as a means of selecting the most appropriate treatment and making sense of complexity, however they may also "create an illusion of neatness" (p.902). Some clinical psychologists noted that NICE guidelines were often at odds with their professional identity, feeling a "pressure to be NICE compliant" (p.904) which stifled creativity, flexibility and limited the ability to express individuality. Difficulty in explaining what a clinical psychologist does, participants thought, may impact on beliefs about the guidance. Particularly it was noted that a common assumption is that adherence to NICE guidelines comes from better knowledge of their contents. However, the study found that all participants were very aware of the guidance, and even thought that strict adherence derives from a lack of confidence in one's knowledge.

Hemsley (2013) conducted a Thematic Analysis of interviews with trainee counselling psychologists regarding the interactions between professional identity and NICE guidelines. Participants considered NICE guidelines were validating for their profession by provided a framework through which to access expertise. The guidelines were described as "pluralistic" in the sense that such a framework provides a "collective identity." These findings are consistent with studies in other areas of complex mental health where inter-agency therapy is often warranted. An editorial discussing NICE guidance for survivors of childhood abuse, for example, illustrated how NICE guidance can conflict. In cases of high comorbidity or complex psychosocial factors, it can be challenging for practitioners to effectively utilize NICE guidance (Gray et al., 2018).

Secondly, articles were coded for interprofessional factors. Network Theory (Higgins & Kram, 2001) suggests that identity construction and modulation is a dynamic process; that is, transformational shifts are characterized by the professional networks in which one interacts. In studies researching team dynamics, individual professional identity was linked closely with team identity. It was recognized that most previous research approached professional identity by exploring static factors, and overlooking dynamic factors (Bentley et al., 2019) yet most clinical interactions around a patient are characterized by multiple professionals with a wide range of expertise (Gazzola et al., 2011).

Teams with a stronger sense of their own identity "were able to make use of their diversity to enhance team effectiveness" (Michell et al., 2011, p.1334). Mitchell et al. (2011) concluded that reflexivity and openness within a team increases resilience to transition. This is neatly described as "dynamically critical reflexive practice" (Hudson et al., 2019, p.353) in a critical ethnographic study of Canadian interdisciplinary medical teams which found that trust between departments and individual managers was a moderating factor for using one's own expertise. Some participants in this study considered the term "collaborative care" to be jargonistic, even "wishful thinking." However, medics in the study noted that strong interprofessional relationships allowed them to test and develop the scope of their own role in the knowledge that their colleagues would support them if they felt out of their depth.

A study of intergroup conflict (Bochatay et al., 2019) concurred with this. Bochatay et al. (2019) interviewed a large heterogenous sample of medical professionals about their experiences of conflict. Steps were evidenced not to impose their own assumptions of the meaning of the term. The authors found that respondents often perceived prejudice based on protected characteristics which impacted on their willingness to be professionally vulnerable or seek creative solutions to problems. Additionally, conflict between professions was associated with power dynamics between individuals, teams and hierarchical structures. This study, however has notable limitations. Within the methodology, the authors invited participants to recount a recent example in which conflict had occurred without operationalising the term in order not to prejudice the respondents. Subsequently, the authors accepted reference to "tension" and "disagreement" as markers of conflict. These terms, however, could signify an expression of effective problem-solving in the manner Gazzola et al. (2011) and Mitchell et al. (2011)

suggested. Thus, conflict may not be associated with the assumed negative connotations in all cases and may represent teams learning to work together and benefitting from one another's expertise.

In contrast, Porter and Wilton (2019) found a positive correlation between professional identity and time spent in the company of one's own professional group. This finding is rather puzzling considering the value placed on exposure to a wide range of professional connections. One hypothesis is that time shadowing one's own profession increases awareness of the potential scope of the profession and tacit skills beyond those learnt in the educational setting (von der Lancken & Gunn, 2019). In this study nurses were required to undertake significant interprofessional shadowing as part of their course and the study analysed a sample from critical reflective logs from course participants. Nurses reflected that shadowing other professional groups not only ameliorated their skill development, but also allowed them to view their own profession critically thereby gaining greater insight into their own professional identity.

- Research question 3: How do multidisciplinary contextual factors affect therapists' professional identity?

Micro and Macro Factors

Theoretical papers (e.g. Hughes et al., 2020; Rose & Norwich, 2014; Wackerhausen, 2009) explored role stereotypes and contextual factors affecting integrated working. Wackerhausen's (2009) key theoretical exploration of professional identity development hypothesized that both macro and micro level factors were important and interlinked. Macro factors are the headline, the heuristic cognitive construct in the mind's eye, in short for Wackerhausen (2009) these are the *raisons d'être* of the organisation. Micro-level factors are those on an individual level; the personal, ethical, professional or other motivating reasons that bring someone to their chosen area of work. Micro level factors contain the discipline-specific terminology which may be technical or jargonistic and relate to team/occupation cultural norms. This can be described as a sense of membership in a professional community, a differentiation between in-group and out-group in Tajfellian terms.

Large organisations such as the NHS have a strong macro-level presence, by which is meant the public face of the organisation, the standards to which the organisation are held and the societal attitudes towards it. Alongside a significant public presence, there are multiple stakeholders who have sometimes competing interests in how organisations should operate which can bring a great deal of scrutiny from word of mouth and press. One needs only to read public commentary about high profile or notable negative cases reported in mainstream media to see negative generalisations about certain professions. A thematic analysis of interviews conducted with social workers (Legood et al., 2019) highlighted that professionals were not only aware of public attitudes held about their profession but that this also increased the risk of internalising negative perceptions and burn-out.

A content analysis of focus groups with healthcare professionals which was rated highly on CASP (Holmesland et al., 2010) concurred that anticipation of role stereotypes seems to be an influential factor. Focus groups conducted with physical and mental health professionals around the topic of team-work and professional identity found that identity transition into new professional networks is greatly affected by role stereotypes and mutual reliance. The authors recommended that team culture and understanding other teams better can reduce group membership barriers. Interprofessional networks enhance specialism (Sweitzer, 2009), reduce siloed working (Kreindler et al, 2012) and aid in negotiating complex problems (Julkunen & Willumsen, 2017). In short, professional identity was found to be significantly shaped through interprofessional collaboration about complex problems (Holmesland et al., 2010) and ameliorated by a strong affiliation to the values of one's profession, a spirit of curiosity, neutrality and reducing hierarchies.

The ability to separate historical discourses from practice is neatly conceptualized as *professional equipoise* (Smith et al., 2015). Smith et al. (2015) utilized this term to differentiate from clinical equipoise defined as "the suspension of judgement about the value of one treatment versus another because one has no good basis for a choice" (p.603). The study adopted a critical discursive methodology to analyse a large sample of historical records selected by field professionals as suitable materials for dominant discourses alongside focus groups. The study found that psychologists were associated with a "conceptual" discourse, nurses with a "caring" discourse and medics with an "empirical" discourse. The authors noted that there were likely to be many exceptions, but that "the dominant discourses and their associated stereotypes…are extremely powerful in interprofessional group dynamics (Smith et al., 2015, p.605)". It is possible that integrated therapists may be affected by such contrasting discourses. Institutionally, NHS Talking Therapies aligns itself with evidence-based practice which seems similar to the empirical discourse, whilst the predominant CBT-orientation of integrated therapists may appeal to the "conceptual" discourse.

In contrast to macro factors, Molleman and Broekhuis (2012) explored how specialist medics' individual personality traits impacted on integrated working for patients with LTC/MUS. A negative relationship was found between traits of extraversion and openness and professional identity in collaborative working. The authors hypothesize that integrated working appeals to extroverted professionals as "they communicate freely, [therefore] they do not easily feel their professional work is threatened if others participate in, or start, discussions on topics within the extravert's domain" (Molleman & Broekhuis, p.61). Individuals who rated lower on emotional stability domains, they found, were significantly more likely to perceive interprofessional discussions as threatening and feel a greater loss of autonomy. No moderating effect was found between extraverted personality and task autonomy or accountability in interprofessional work. The authors hypothesized that extraverted professionals may feel restricted and dislike feeling accountable to others. The study provides empirical support for the role of personality and power in multiprofessional and specialist teams as they resolve complex health problems. The authors acknowledge that there remains unexplained variance which they hypothesized might relate to stakeholder demands, levels of transparency and leadership style of immediate managers.

Discussion

The findings from this review have potential for enhancing the sustainability and success of the integrated pathway. There are plentiful opportunities for integrated therapists to respond to the needs of LTC/MUS populations with effective and tailored treatments, further augmented by being part of a collaborative network.

Our first research question sought to understand how well integrated therapy is understood. It seems that all stakeholders accept the moral argument for the creation of the integrated pathway but this can be elusive to definition. When such expectations were lacking or unclear, professionals report greater discomforted and a weaker sense of their professional identity. Supervision is often assumed to fulfil learning/develop needs, reinforce organisational values and encourage reflexive practice, yet is also plagued by inconsistency and has weaker effects on patient outcomes that one might assume (Simpson-Southward et al., 2017). Effective oversight supports psychotherapists to respond to the varying needs of their client collaboratively and holistically (Gill et al., 2025). Specialist roles often benefit from clear role differentiation amongst colleagues and referrers (Woo et al., 2016) whilst inexact parameters risk poorer service utilisation, and therapists' ability to align their values with the full scope of the profession. Integrated therapy utilizes the skillset of all in the network, rather than simply assigning tasks according to profession. Therapists may want to know, for example, whether a client's avoidant behaviors are medically advisable or a perpetuating safety-behavior, whilst a

physiotherapist may want to work with a therapist and client to explore the role of trauma in pain management. Effective interprofessional care within a complex adaptive system requires creating spaces for ideas and new professions to participate, overcoming communication gaps such that professions complement each other through negotiation and shared identification with the network's values (van Heteren et al., 2025).

Secondly, we wanted to explore the most influential identity junctures in professional identity modulation. For some, identity modulation is akin to a "brand" which one needs to make visible to an external observer (Branzetti et al., 2025), in which care should be taken to mould the view of referrers, colleagues and the public to emphasize novel role values and functions (Smith et al., 2015). Indeed, the review has found macro level factors to be of great importance. Whilst a source of uncertainty, this could be a great opportunity. As a well-publicized policy priority, therapists may benefit from the "spotlighting effect" (Wu et al., 2024), in which high profile public awareness events offer opportunities to frontline professionals to reflect on their shared values and distinctive skills that set them apart. Congruence between responsibilities and values is considered the most important factor for successful adaptation, whilst role differentiation, continued knowledge development and clinical experience with regular feedback have been found to be influential factors in successful professional identity modulation (Gibson et al, 2023). Whilst initial training is a significant transition point in professional identity, an effect which remains stable amongst longer qualified professionals, therapists are often trained in uniprofessional environments. Formal training opportunities and networking conferences may facilitate identity development as part of an interprofessional system. Accrediting bodies and practice guidelines appear to provide some structure for accepted behaviors, attitudes, values as well as recommended treatments which connect a professional to their scope of their role. Professional learning theories suggest that attending both to one's own profession, and facilitating interaction with a range of professionals in the collaborative network is likely to develop and maintain the necessary skills (Khalili & Orchid, 2020) Therapists who learn an additional modality post-qualification tended to fare better when reflexivity was overt and encouraged, alongside adherence to therapeutic frameworks (Ball & Corrie, 2024). Therefore, providing opportunities for integrated therapists to engage with a range of learning opportunities (behavioral, cognitive, humanistic and constructivist) is considered to enable professionals to address complex clinical practice questions as part of a sustainable system (Khalili, 2025).

Conclusion

This study found that the creation of the integrated pathway is likely a key transition point for Psychological Therapists. Although there is a strong desire on the part of NHS Talking Therapies, and indeed psychotherapists to collaborate and integrate evidence-based therapies with their physical health counterparts, there remain challenges to overcome regarding roles, responsibilities and what form this should take. Interprofessional collaboration is often defined by its instability, yet this is also part of the opportunity. Services providing integrated therapies would be advised to facilitate opportunities for reflexive practice within their own profession, and to communicate this visible outside. Further, a cohesive sense of interprofessional identity is only possible with regular channels of interaction. It is therefore recommended for organisations to conduct regular networking opportunities and feedback.

Limitations

The literature review utilized identification, extraction and data synthesis methods widely used in qualitative research. Using an inductive heterogenous search strategy allowed for a wide range of literature to be sourced and meant that the search could be refined based on

the content being sourced. As with any literature review, there are limitations. The search terms were initially generated by the researcher. The terms were reviewed and extended based on feedback from peers in the field of psychological therapy in order to broaden the search terms without compromising relevance, however it remains possible that greater sensitivity of search terms may yield other relevant papers.

Secondly, studies were excluded if they had a clear secondary care perspective. It is possible that such studies may be able to offer insight into factors also suitable for integrated workers as they are likely to have some shared characteristics such as experience of service transformation, and likelihood of working with clients with comorbidities, likewise patients with severe mental illness are likely to find similar challenges when accessing integrated care (Melamed et al., 2019). Indeed, a recent literature review highlighted complexities within NHS Talking Therapies clinical populations suggesting that boundaries between primary and secondary care are not always mutually exclusive, and that there is a need to increase the interface more greatly between primary and secondary care mental health services (Martin et al., 2022).

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Notes on Contributors

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