How do counselling psychology trainees experience working with CBT in their placements?

by

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ABSTRACT

Rationale: This study set out to provide an open investigation into how trainee counselling psychologists in the UK experience working with cognitive behavioural therapy (CBT) in their placements. Research and commentary by qualified and trainee counselling psychologists have expressed some concern about how well the profession's values are upheld when they are working with CBT within the NHS and IAPT settings. However, it is unclear how widely these concerns are shared amongst counselling psychologists the majority of whom work in the NHS. Furthermore, the relevance of these concerns to trainees who may work with CBT in a wide range of other clinical settings within the public, charitable, and private sector was uncertain. **Method:** Interpretative phenomenological analysis was used to explore six final-year trainee counselling psychologists' lived experience of working with CBT in their placements. Data was collected through semi-structured interviews via Skype. **Findings:** It uncovered three interconnected superordinate themes: (i) Pure CBT work vs. integration (ii) CBT conflicts with counselling psychology's values, and (iii) Deconstructing & assimilating CBT. These findings were interpreted and discussed in relation to the existing literature. The key finding was that the participants' belief in professional values often led them to feel frustrated with their work in CBT placements and with supervisors that expected them to only work with CBT as a stand-alone-approach. In this regard, the participants' primary training in person-centred therapy or psychodynamic therapy and their preference for integrative approaches was deemed significant. The dissatisfaction reported by the participants concerning their CBT experiences was largely consistent with previous studies. The methodological limitations of the study are discussed and recommendations are made for further research to investigate the extent of these concerns and what could be done to address them.

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1. REFLEXIVE STATEMENT

> The process of reflexivity is an attempt to identify, do something about, and acknowledge the limitations of the research: its location, its subjects, its process, its theoretical context, its data, its analysis, and how accounts recognize that the construction of knowledge takes place in the world and not apart from it (Shacklock & Smyth, 1998, p. 6)

Research produced without acknowledging the cultural and historical background of its researchers would fail to provide a complete picture of their findings (Burr, 2003). This is especially true in more subjective, qualitative research where the importance of reflexivity is well established (e.g., Finlay, 2002; Shaw, 2010). Flood (1999) has commented that research without reflexivity could be blind and without purpose. At the beginning of the research process, my reflexive statement attempts to explore how the (co)-construction of knowledge in this study may be influenced by my pre-existing views, assumptions, feelings, and investment in the topic.

My first experience of counselling was an introduction to counselling skills that taught both person-centred and psychodynamic theories. On the one hand, I was impressed by Carl Rogers' (1957, 1961) humanistic, person-centred therapy and how the 'core conditions' of empathy, congruence and unconditional positive regard could facilitate a therapeutic environment and relationship with clients. On the other, I believed that person-centred therapy was limited by its non-directedness. Perhaps unfairly, I felt that it often avoided addressing a client's questions and placed too much emphasis on diverting attention back to the client with questions such as '…and how does that make you feel?'. I also thought that psychodynamic therapy with its roots in Freudian ideas of unconscious processes,

early developmental and attachment theories, whilst offering fascinating insights, appeared to be based on sweeping assumptions that were hard to prove.

I was immediately impressed with CBT which drew my attention as an alternative therapeutic approach to consider. Unlike person-centred therapy, it engaged actively with clients in problem-solving exercises, and, unlike psychodynamic therapy, CBT interventions seemed rational and made intuitive sense. Furthermore, as a novice there seemed to be a wealth of materials and resources to use with clients, including session plans and agendas.

Having completed a certificate and diploma in CBT through distance learning I worked as a trainee counsellor for a secondary school and later for a charity for adults with chronic mental illness living in the community. During my work with teenagers, I tailored the CBT in an age-appropriate fashion, and sometimes incorporated artwork into sessions to help my clients express their emotions. At the community mental health resource centre I saw how CBT could also be applied to helping adults. I was impressed with how CBT could be adapted to help clients of different ages and used to treat a wide range of mental health problems. The improvement I saw in my clients' emotional wellbeing was rewarding which strengthened my resolve to pursue a career as a therapist.

I applied for a professional doctorate in counselling psychology because I believed it offered superior training compared to other courses and would open the door to greater career opportunities. My first year placement as a trainee counselling psychologist was in CBT at a university counselling service that offers six sessions of time-limited therapy. During this placement I treated adults with a wide range of mental health problems

including anxiety, depression, health anxiety, obsessive compulsive disorder, body dysmorphic disorder, and low self-esteem. The placement started before many of the introductory lectures on counselling psychology and CBT had begun. So initially, I practised CBT based on what I had already learnt prior to commencing training. However, my training in counselling psychology changed my view of what my professional role should be when working with CBT.

My training encouraged a pluralistic stance in which all theoretical approaches' strengths and weaknesses should be critically evaluated. It also encouraged me to examine the dynamics of the therapeutic relationship and my role as a trainee counselling psychologist. Specifically, it caused me to recognise how the relationship between myself and my clients can be an important vehicle by which to reveal and address interpersonal dynamics that can both guide and inform effective therapy. This has drawn upon concepts that are more closely aligned with psychodynamic theory than CBT, and has encouraged me to consider what other theoretical approaches could offer. In turn, this has caused me to be more aware of the intentions behind my actions and the emotions being expressed within the therapeutic relationship.

During the first year of the course, my perception was that I, and fellow students on my course, often felt frustrated in our placements because we perceived that our ability to focus on the therapeutic relationship in CBT was restricted. In this respect I found that time-limited therapy had on occasions left little room to stay with my client's emotional state in therapy or to explore experiences in depth for fear of not progressing with the agenda. Other students on my course reported similar experiences in their placements where they were using a manualised-based approach to CBT. I believed that such

experiences in CBT placements would be familiar in many therapy services, because it seemed likely that time-limited therapy and strict adherence to protocols were used as solutions to the problem of addressing long waiting lists and meeting performance targets.

This perception was challenged during placements I had with an Improving Access To Psychological Therapies (IAPT) service, a private therapy centre, and with addiction services. In these placements my counselling psychology supervisors showed that humanistic and psychodynamic insights and techniques could be incorporated into my short-term CBT work when conceptualising or formulating a client's problems, which included exploring the dynamics that occurred within the therapeutic relationship. My experience of using CBT as a longer-term treatment also underlined, and I became more aware of, the need to recognise unconscious dynamics in the therapeutic relationship when clients became overly dependent on their therapist and their therapy sessions.

The significant role that CBT has played in my personal experiences as a therapist before and during training has given me an interest in the relationship between CBT and the training of counselling psychologists. As a counselling psychology trainee, my experiences have made me acutely aware of the role of clinical placements in shaping my own views about CBT and the counselling psychology's values. Self-evidently, however, my experiences of CBT represent only my perspective and I was interested to know how other trainees had experienced their CBT placements in different clinical settings and if there were any explanations for similarities or differences in these experiences.

In reviewing relevant literature on this topic, I focused initially on research concerning the relationship between counselling psychology's values and CBT. This revealed a distinct

counselling psychology perspective so the potential bias in these views was noted and attempts were made to articulate competing or alternative views where possible. The critical literature review explores this topic and has helped to develop my understanding of the relationship between CBT and counselling psychology.

2. INTRODUCTION TO CBT AND COUNSELLING PSYCHOLOGY

A trainee counselling psychologist's work with CBT on clinical placements is influenced not only by what happens inside the therapy room but also by social, cultural, economic and political forces outside that shape mental health service provisions. This chapter explores these forces and how they have informed the clinical settings and type of therapy trainees may practise. This includes the development of CBT as an evidence-based practice and its expansion by the National Health Service (NHS) through the Improving Access to Psychological Therapies (IAPT) initiative. These developments have contributed to CBT becoming a popular form of psychological therapy offered in the UK. This popularity is reflected in the growing importance of CBT in the context of counselling psychology training, clinical placements, and trainees' professional development.

2.1 The Developments of CBT

The British Association for Behavioural and Cognitive Psychotherapies (BABCP) defines CBT in the following way: "cognitive behaviour therapy is variously used to refer to behaviour therapy, cognitive therapy, and to therapy based on the pragmatic combination of principles of behavioural and cognitive theories" (BABCP, 2018, p.2).

Cognitive behaviour therapy (CBT) has become the dominant force in psychotherapy in North America, the United Kingdom, much of Europe, and increasingly throughout Asia and Latin America (Herbert & Forman, 2011). The rise of CBT is due to the confluence of several factors, primary among which is the increased focus on evidence-based practice and associated calls for accountability in the delivery of behavioural health services (Baker, McFall, & Shoham, 2009).

Since the 1950s/60s there have been three stages of CBT development, also known as waves (Westbrook, Kennerley, & Kirk, 2011). Each wave is associated with different methods and approaches to CBT therapy. The first wave is linked to behavioural therapy which has a long and established tradition in psychology stemming from the work of Pavlov, Thorndike, Watson and Rayner early in the 20th century and including developments made by Wolpe and others in 1950s (Burns & Worlsey, 1970). Behavioural therapy seeks to help clients to develop new associations to environmental stimuli and thereby elicit different responses and it has become a successful treatment for anxiety through desensitisation. It arose as a reaction against the Freudian psychodynamic paradigm that dominated psychotherapy from the 19th century onwards, and led to questioning of the empirical evidence that supported the theory or effectiveness of psychoanalysis on the grounds that unconscious processes were not directly observable or scientific (Eysenck, 1952; Westbrook et al., 2011).

The second wave, which arose from the foundations set by the work of Ellis and Beck in the 1960s, incorporated cognitive therapy. Ellis's (1962) work on rational emotive therapy introduced the idea that psychological distress could be treated with reason, whilst Beck (1976) found that depression could be treated by challenging the negative thoughts and interpretations associated with low mood. Their work helped to fuel the cognitive revolution in psychotherapy that enabled clients' problems to be understood and helped by an examination of conscious processes as well as the unconscious that had been the traditional approach. The main focus of cognitive therapy, at least most of the time, is on what is happening in the present and the processes currently maintaining the problem, rather than the processes that might have led to its development in childhood (Westbrook et al, 2011). The behavioural and cognitive approaches of CBT were joined in the 1970s

(Westbrook et al, 2011). Originally used to treat depression (Beck, 1979), over the last four decades CBT has been used to treat, amongst others: anxiety, social phobia, obsessive-compulsive disorder (OCD), post traumatic stress Disorder (PTSD), and psychosis (Tai & Turkington, 2009).

The third wave of CBT included new approaches such as Acceptance and Commitment Therapy (ACT) developed by Hayes, Strosahl & Wilson (1999), Dialectical Behavioural Therapy (DBT) by Linehan (1993) and Mindfulness-Based Cognitive Therapy (MBCT) by Segal, Teasdale, Williams, & Gemar (2002). They have taught how to accept and tolerate unpleasant thoughts and feelings rather than challenge them. These innovations focus on processing thoughts or feelings rather than their contents (Winter, 2008). Some have argued that this third wave is a direct extension of CBT and is firmly grounded in the traditional approach by addressing metacognitive content and other cognitive processes (Forman & Herbert, 2009). Conversely, others see it as a significant departure from second wave approaches in view of their seemingly opposing ways of treating clients' thoughts and feelings (Winter, 2008; Hayes, 2004). The third wave has led some to conclude that the CBT label offers no clear or useful definition and that to talk about it as if it were a single therapy could be misleading (Winter, 2008). From this viewpoint modern CBT is not a monolithic structure but an umbrella term that includes a diverse group of treatments (McMain, Newman, Segal, & DeRubeis, 2015).

Hoffman, Asnaani, Vonk, Sawyer & Fang (2012) reviewed CBT's evidence-base by sampling 106 meta-analytic studies published before 2004 out of a total of 269 they identified. They found that CBT was at least as effective and was often better than other psychotherapies or psychopharmacological interventions as a treatment for the following

problems: depression, bipolar disorder, schizophrenia and other psychotic disorders, personality disorders, insomnia, eating disorders, substance use disorder, criminal behaviours, distress due to general medical conditions, chronic pain and fatigue, and distress related to pregnancy complications and female hormonal conditions. The study showed that CBT was particularly effective as a treatment for general stress, anxiety disorders, anger control problems, bulimia, and somatoform disorders. The only exception was that psychodynamic therapy was found to be a superior as a treatment for personality disorders (Hoffman et al., 2012).

While the authors concluded that CBT's efficacy was strong, many meta-analyses were potentially unreliable deriving evidence from studies with small sample sizes and inadequate control groups (Hoffman et al., 2012). The 2004 cut-off date also meant that a significant number of meta-analyses published between 2004 and 2012 were not reviewed (Hoffman, et al., 2012). The increasing number of meta-analyses being published is a reflection of the growing wider interest in CBT in recent years, for example, while there were less than 2,000 CBT related articles in the PsycINFO database between 1995 and 1999, the number increased to over 12,000 articles between 2010 and 2014 (Dobson & Dobson, 2018).

This growing body of literature often references CBT's evidence-base. However, the evidence-base itself has been questioned (Hoffman et al., 2012). Concerns include, amongst others, the way random controlled trials are conducted with no valid alternative to CBT, and the selection of participants with a single mental health problem which does not reflect everyday practice where clients often present with multiple problems (see Henton, 2012; Shedler, 2017).

The evidence-base is often cited as the reason why CBT should be considered the treatment of choice for many, if not most, mental health disorders (Leichsenring & Steinert, 2017). It has also helped to establish CBT as a major theoretical orientation in psychotherapy (Roth and Fonagy, 2005). Consequently, there are keen debates on the methodological limitations identified in CBT's evidence-base, and where they are acknowledged, on whether changes to existing CBT practices are required (e.g. Leichsenring & Steinert, 2017; Lorenzo-Luaces, 2018). Currently, the prevailing consensus appears to be that the weight of evidence supports CBT as a preferred evidence-based treatment for a wide range of mental health problems and that these methodological issues are not sufficient to warrant change.

2.2 CBT and NICE, NHS and IAPT

The use of CBT in the UK has increased significantly over the last decade. This has been possible because of government investment in NHS mental health services through an estimated £700 million investment in IAPT since 2007 (Binnie, 2015). In 2005, Lord Layard, an economic and political advisor to the government, produced a report called *Mental health: Britain's biggest social problem?*. The report made a strong argument that increased investment would improve the mental health of the nation and, by reducing expenditure on welfare and increased economic activity, would save the government money.

IAPT was the flagship initiative to implement these ideas. After a pilot study, it was rolled out across the country with a £300m investment between 2007/08 and 2010/11 and an additional £400m pledged for 2011/12 to 2014/15 (Department of Health [DoH], 2012). In November 2012, IAPT's 3 Year Report claimed that 1,000,000 patients had been seen,

680,000 had completed treatment, 250,000 had shown signs of reliable improvement and 45,000 had stopped claiming sick-pay and welfare benefits (DoH, 2012).

The National Institute for Health and Clinical Excellence (NICE) has played a key role in advising IAPT about which therapies to offer patients based on cost-effectiveness and best evidence-based practice. It has recommended CBT as the therapy of choice for most of the psychological disorders including: Schizophrenia (NICE, 2009a); Depression (NICE, 2009b); Eating disorders (NICE, 2004); Generalised anxiety and panic disorder (NICE, 2011); Post-traumatic stress disorder (PTSD) (NICE, 2005a); Obsessive compulsive disorder (OCD) and Body dysmorphic disorder (BDD) (NICE, 2005b).

In order to meet the demand for these services IAPT has trained an estimated 9,000 new high-intensity and low-intensity CBT therapists (DoH, 2012). This was part of a stepped care programme in which patients with mild severity of symptoms (step 2) were treated by low intensity CBT therapists, renamed wellbeing practitioners, while patients with severe severity of symptoms (step 3) were treated by high intensity CBT therapists who had undertaken further training (Binnie, 2015). The main role of the psychological wellbeing practitioner is to help clients engage with self-help material; it has been likened to that of a 'CBT self-help coach' (Branson, Myles, Mahdi, & Shafran, 2018). Psychological wellbeing practitioners see clients suffering from mild to moderate symptoms of distress associated with depression, panic disorder, generalised anxiety disorder (GAD), and OCD (PWP Training Review, 2015). High-intensity CBT therapists also treat clients with these disorders as well as those suffering from social phobia and PTSD, but the focus is on helping clients with more severe levels of distress via one to one therapy sessions (PWP Training Review, 2015).

High-intensity CBT therapists are usually mental health professionals such as clinical or counselling psychologists who have undertaken further training as part of the BABCP accreditation process (Curran, Houghton & Grant, 2010). The BABCP has grown in prominence with the rise of IAPT and its CBT training programme and the insistence on IAPT practitioners being fully accredited with BABCP meant that even senior and experienced therapists were required to 're-train' (Bor & Watts, 2016).

The BABCP's website suggests that, in addition to demonstrating professional integrity and a commitment to CBT, accreditation may be required by some employers; and that some health insurance companies will only authorise CBT treatment from a BABCP-accredited therapist (Introduction to Accreditation, 2018). For these reasons counselling and clinical psychologists may be incentivised to apply for BABCP accreditation. It is possible for a trainee to gain accreditation based on their clinical and academic work but a criterion is that work has to be supervised by an accredited BABCP supervisor. Due to a general lack of such supervisors this may not be possible in many placements in which trainees may practise CBT (Curran et al., 2010). It is likely, therefore, that newly qualified counselling psychologists will need to demonstrate additional training experience in CBT before they are fully recognised by the BABCP.

IAPT has been described as the biggest shake-up of mental health ever seen in the UK (Rizq, 2011). The championing of CBT by NICE and IAPT has had far-reaching implications for other mental health providers. Through the UK's 152 Clinical Commissioning Groups (CCGs) the government is committed to investing in the best quality and most cost-effective care for its patients. This includes offering community

mental health contracts to Any Qualified Provider (AQP) who meets their quality standards (Reynolds & McKee, 2012). NICE recommendations on CBT apply, therefore, to any private or charitable company wishing to compete for IAPT services. Private health insurance companies have also adopted NICE recommendations as part of their risk management and quality control when recommending therapy services to their clients (Fairfax, 2008).

The increased spending on mental health services through IAPT is widely regarded as a significant accomplishment. However, the three year report by IAPT says there is room for further improvement, including plans to expand mental health services to patients that have so far been under-represented. It has promised to increase access to children, young people, the elderly, and those with long-term physical or mental health conditions including severe mental health illness and personality disorder. Furthermore, 30% of new high-intensity therapists will also be trained in Interpersonal Psychotherapy, Brief Interpersonal Psychotherapy, and Counselling for Depression as recommended by NICE as treatments for depression (DoH, 2012).

The progress of IAPT as reported by the Department of Health appears to have supported Lord Layard's (2005) economic case for investing in mental health services in the UK. Notwithstanding the real progress made in improving access to psychological services for many NHS patients, the initiative has come under criticism. In 2015, MIND, a charity that campaigns to improve mental health services, in coalition with organisations such as the British Psychological Society and the British Association for Counselling Psychotherapy, claimed that many service users' experiences of IAPT had been poor. Their survey of 1,600 service users found that 10% of patients had been waiting over a year for treatment

and over 50% had waited over three months. 50% thought the number of sessions was insufficient and 58% were not offered a choice of therapy (MIND, 2015). The survey suggested that IAPT attempts to meet the high demand for its service have resulted in many service users experiencing a poor quality of service with long waiting lists, overly brief therapy, and no say in the type of therapy received.

Nevertheless, recent figures suggest that around 50% of IAPT's clients recover, with a further 25% showing 'worthwhile benefits' (Clark, 2018). A 50% recovery rate has been a long-term goal for IAPT, and it can, therefore, be seen as an important metric with which to evaluate the success of IAPT and the efficacy of CBT as its most widely-used psychotherapy.

However, the figure may be inflated by unreliable diagnostic interviews and recovery rates based on clients' self-assessment questionnaires in their final therapy session (Williams, 2015; Scott, 2018). A study by Scott (2018) using clinical diagnostic interviews and factoring in long-term recovery found that recovery rates were as low as 24%. While this study was based on a relatively small sample, it raises questions about IAPT's reported success and the efficacy of its evidence-based CBT treatments (Timimi, 2018). Nevertheless, IAPT has yet to announce any changes to the way recovery rates are reported. Furthermore, low rates of recovery, as it is recognised in some services, have been interpreted as a sign that CBT practitioners need to adhere even more closely to NICE's recommendations on evidence-based treatments (Clark, 2018; Scott, 2018).

As a result of IAPT, CBT has enjoyed very strong political and economic support relative to other psychotherapies. There are currently plans with additional funding to expand IAPT

as part of a 5-year plan to treat 1,500,000 clients per year by 2020 (Clark, 2018). Since its inception IAPT has received an estimated £1 billion (Timimi, 2018), a level of expenditure that is somewhat contentious for those who question CBT's evidence-base and believe that IAPT should be offering its clients valid alternative therapy options.

In the UK the NHS's IAPT service has contributed towards a popular discourse that defines CBT as a disorder-specific, short-term, evidence-based treatment. However, this discourse is dominated by political and economic interests and does not reflect the diverse ways in which CBT is practised. For example, the emphasis on short-term CBT reflects how it has been promoted as a cost-effective treatment for the NHS, but in private practice clients and therapists may choose to work with CBT over a longer time-frame. Practitioners and services may also use CBT as a transdiagnostic approach to treat multiple problems rather than as a disorder-specific treatment (Mansell, 2012). CBT can also be used with other approaches as part of an integration strategy (e.g. Lambert, 1992; Norcross & Goldfried, 2005; Ward, Hogan, & Menns, 2011). These alternative ways of using CBT show that it can be understood to be a social construct with different meanings and clinical applications.

2.3 Role of CBT and Placements in Counselling Psychology Training

Standards for the accreditation of Doctoral programmes in counselling psychology state that, by the end of their programme, trainees will be able to relate their philosophical understanding of counselling psychology and its evidence-base to their practice. The British Psychological Society (BPS, 2014) Division of Counselling Psychology's training standards committee proposes that trainees should:

1. Demonstrate in-depth critical knowledge and supervised clinical experience of the particular theory and practice of at least one specific model of psychological therapy (a model of psychological therapy is defined as a particular therapeutic approach in relation to which there is a body of theory and research which has implications for therapeutic practice; and that offers an explanation with internal consistency about the nature of the person, of psychological difficulty, of the therapeutic relationship, and of the process of change);

2. Have a working knowledge and supervised clinical experience of at least one further model of psychological therapy (working knowledge is defined as the ability to apply theory into therapeutic practice);

3. Be able to compare, contrast and critically evaluate the ontological and epistemological foundations underlying a range of models of therapy;

4. Be able to provide psychological therapy interventions: (i) to individual adults and depending on placement experience other client groups including children and young people, older adults, couples, groups, families, and organisations; (ii) in range of contexts, which may include NHS (primary, secondary and tertiary care) and other statutory, voluntary or independent settings; and (iii) working within different time-frames of therapeutic practice (time limited, short and long-term, as well as open-ended therapy). (p. 21)

CBT is central to this training process and internet research of the course content of BPS-accredited counselling psychology programmes in the UK revealed that it was offered by all thirteen courses. In 2018 CBT was taught as an elective module by one course, as a primary model by five courses, and as a secondary model by the other seven. In comparison, person-centred therapy was taught as a primary or secondary model by six

courses as was psychodynamic therapy, and existential-phenomenological therapy was taught by only two courses.

Clinical placements within the training programmes have been described as a cornerstone of counselling psychology trainees' professional development (Kahr, 1999). They represent the primary route by which professional competencies for translating theory into practice are developed. Trainees have to demonstrate these competencies by completing a minimum of 450 hours of supervised face-to-face work with clients in clinical placements over three years full-time or up to five years through part-time study. Gaining placements in counselling psychology is notably different from clinical psychology, psychiatry and social work because placements are sought independently by the trainees and not arranged by their training courses (Kahr, 1999). Furthermore, unlike clinical psychology, counselling psychology trainees are not employed by the NHS. They do not receive financial aid or a bursary and are not paid for their work on placements. Consequently counselling psychology trainees have reported stress due to the financial pressures of funding their courses (Bor, Watts, & Parker, 1997).

The obligation to find their own placements has also been seen as a problem for trainees because they need to gain a wide range of comparable experiences in order to claim the full range of competencies in the job market. Kahr (1999) notes that other professions would have worked with nearly every age group from children to the elderly through structured placements and with almost every diagnostic group by the time they qualify. Finding suitable placements that develop competencies and enhance future prospects is understandably a significant cause of stress (Kumary & Baker, 2008). Such pressure may be exacerbated by unrealistic expectations that trainees may hold about their training

including an assumption that they will be ‘experts’ by the time they complete their courses (Efstathiou, 2017; Szymanska, 2002).

On the other hand, the fact that counselling psychology trainees are not NHS employees and are under no contractual obligations to work in NHS settings means they are free to seek their own experiences and access to a wide range of placement settings. This is seen as an opportunity for these trainees (Van Scoyoc, 2005; Walsh, Frankland, & Cross, 2004) who have been known to work in a wide range of settings including services for pain management, addiction, and university counselling. Placements in NHS primary care, secondary care, and tertiary care or specialist services have also been encouraged by training courses (Ramsey-Wade, 2014). The exact variety and frequency of placements and the theoretical models used by trainees is unknown as no national database exists of where trainee placements have been undertaken (Ramsey-Wade, 2014). However, trainees are likely to work with CBT in a wide variety of contexts and clinical settings.

Qualified counselling psychologists are known to work in a variety of roles in the public, private and charitable sectors including forensic, organisational, academic, legal and independent practice (Strawbridge & Woolfe, 2010). Although their training is not paid for by the NHS, it has established itself as a key employer with an estimated 37% of all Counselling Psychologists working in this area in 2012 (Orlans & Van Scoyoc 2009; Milton, 2012). Indeed working in the NHS has been seen as a measure of accomplishment by many in the profession (Strawbridge & Woolfe, 2010).

The literature review explores what qualified and trainee counselling psychologists have reported about working with CBT. It sheds light on important issues concerning the role of

CBT placement in the context of counselling psychology training and the role of counselling psychology's values in CBT services.

3. CRITICAL LITERATURE REVIEW

The literature search for this review used a number of academic databases including Google Scholar, Ethos, PsycInfo, and Counselling Psychology journals such as the Counselling Psychology Review. The search terms used included 'counselling psychology', 'counselling psychology training', 'CBT experiences', 'professional identity', 'professional values', 'the therapeutic relationship in CBT' and 'theoretical orientation'. It reveals that research exploring the relationship between counselling psychology and CBT consists primarily of theses by trainee counselling psychologists (e.g. Mantica, 2011; Stapley, 2014; Verling, 2014); and a large body of commentary by trainee and qualified counselling psychologists. The findings of this review suggest that experiences of working with CBT may be influenced by professional values, and a therapist's theoretical orientation.

A wider literature search was then conducted to include research and commentary from CBT therapists, and other psychotherapists. It provides an alternative perspective on some of the issues raised. In addition to the existing studies that have focused on issues concerning counselling psychology's professional values or professional identity, the literature review also revealed that an open investigation is needed into how counselling psychology trainees experience their CBT placements.

This broad literature base draws upon a wide range of sources such as the commentary, diverse qualitative and quantitative research from qualified and training counselling psychologists, and other applied psychologists in the UK and other countries. The different assumptions made by researchers about the nature of the phenomenon they are investigating are representative of divergent views of ontology (or the study of being) and

epistemology (or the study of knowledge) and of the use of different methodological approaches to collect evidence (Crotty, 1998). These research issues and the positioning of commentary from authors are also considered.

3.1 Professional values

Compared to most other applied psychological therapies counselling psychology is relatively young having only gained full divisional status as a separate profession within the BPS in 1994. The identity of counselling psychology and its values that bind its members together and differentiate them from others have been widely researched. This work includes important contributions by academics such as Pugh and Coyle, (2000); Cooper (2009); Hemsley (2013) and recent theses by counselling psychology trainees Stapley (2014) and Verling (2014).

Pugh and Coyle (2000) researched the change in discourse between the 1990 and 1996 volumes of the Counselling Psychology Review journal. This analysis was then updated by Hemsley (2013), for changes between 2007 and 2009. The importance of humanist principles and values is expressed throughout these papers. Their discourse analysis revealed how counselling psychology as a profession has actively sought to differentiate itself from others by emphasising its relational approach and humanistic values.

The acquisition of professional values by counselling psychology trainees was researched by Stapley (2014). This doctorate thesis used a constructivist grounded theory from a sample of nine participants. The study highlighted that counselling psychology trainees are continuously defining their professional identity through their experiences in training. This

includes their positive and negative experiences of supervision, personal therapy, clinical placements, academic training and work, and the socio-political climate.

Verling's (2014) doctorate research also illustrated how counselling psychologists' interpretations of their professional values can vary. The research consisted of a mixed method study, a survey of 41 participants (28 qualified counselling psychologists, and 13 counselling psychology trainees) and an IPA study with 6 qualified counselling psychologists. The overall conclusions were that no single professional identity existed but that all participants described therapeutic values, aligned with a humanistic philosophy, as part of their own unique professional identity. The diversity in personal interpretations of the profession's identity was ultimately unified by these humanistic values.

The subjectivist epistemology and relativist ontology of the research from Verling (2014), arguably resulted in a deconstructionist perspective from which differences between participants were observed but not similarities. However, Verling (2014) makes a compelling case that professional values such as pluralism, a humanistic perspective, and the therapeutic relationship are not uniformly understood by counselling psychologists. Instead she argued that they provide a framework within which counselling psychologists and trainees can develop their own professional identity through learning and clinical experience.

3.1.1 Pluralism

Cooper & McLeod (2011), describe counselling psychology as a post-modern, pluralistic approach to therapy, employing various methods of therapeutic enquiry and practice in order to meet the clients' needs in a non-prescriptive manner. This pluralism of approach

sets counselling psychology training apart from other therapy courses that only teach one therapeutic approach. In practice, pluralism is a recognition that each client is unique, and may require therapies to be tailored to meet very different therapeutic needs (Cooper, 2008). This does not imply an uncritical acceptance or unwavering faith in all approaches but a healthy enquiring stance and an ability to appraise therapeutic approaches and their suitability for individual clients (Rizq, 2006).

Rizq (2006) wrote that pluralistic philosophy can create uncertainty in trainees who are taught to consider diverse models or approaches when working with clients and are prevented from making a close affiliation with a single theory. Trainees who are aware of alternative ways of working, with often radically different paradigms and perspectives, may ask 'What is the right model or correct intervention?' or 'How can the differences between models be reconciled?'. Management of the potential challenge to trainee counselling psychologists arising from the fact that pluralism does not offer a simple set of rules to follow can create the space for a personal engagement with the theoretical, clinical, and academic material presented during training and thereby helping to transform a novice helper into a professional therapist (Rizq, 2006).

'Pluralism' as a philosophy does not describe how a pluralistic perspective may be implemented. Often it leads in practice to the selection of an appropriate therapy for a client involving the use of only a single model. However, 'pluralism' has been implemented by therapists through 'pluralistic practice' or 'integration' where they draw on two or more models to inform a client's treatment. Three forms of integration have been identified:

1) An ‘integrative approach’ which combines different theoretical approaches in a distinct way, with its own internal consistency (Norcross & Goldfried, 2005).

2) ‘Assimilative integration’ which combines techniques or interventions from alternative schools of thought into a pre-existing model or approach to therapy (Norcross & Goldfried, 2005).

3) An ‘Eclectic approach’ which simply uses interventions from different theoretical schools of thought (Norcross & Goldfried, 2005).

Counselling psychology courses typically teach therapeutic models independently of one another and students are then encouraged to consider the similarities and differences between them. Depending on the course, some students are also encouraged to explore integration strategies (Ward et al., 2011).

In 2011, a thematic analysis of the experience of integration in counselling psychology programmes was conducted (Ward et al., 2011). It included the accounts of six counselling psychology trainees who reported valuing the opportunity to learn about integration but were often confused as to how it should be implemented in practice. In this area, they would have welcomed more practical guidance from their course providers. Notably, they often incurred difficulties when their theoretical allegiance to pursue integration did not align well with the views of their supervisors or their placements.

These themes were also found in a thesis by Hapney (2016), a thematic study of how fifteen qualified counselling psychologists experienced integrating two or more models in their practice. The study found that many grappled with the problem of how to achieve a theoretically coherent view of their clients through integration. The less experienced

counselling psychologists also described the challenge of pursuing integrative strategies in NHS and IAPT services, where there was an expectation that they would be working in prescribed ways, with the pluralistic and humanistic ethos of their profession.

In the studies by Wade et al., (2011) and Hapney (2016) the approach of many of the participants could be described as 'assimilative integration' in which they used insights and techniques from other models within a CBT framework. It was evident from their accounts that they were trying to achieve this in NHS and in IAPT services where their supervisors were not experienced in integrative strategies and, therefore, could not support them in this direction.

3.1.2 The Humanistic perspective

Cooper (2009), also an advocate of pluralism in counselling psychology, has been particularly influential in exploring and clarifying a professional identity for the profession. Through an analysis and amalgamation of different sources, Cooper (2009) identified six key humanistic principles of counselling psychology: -

1) Prioritisation of the client's subjective and intersubjective experiencing, as opposed to prioritisation of the therapist's observations or 'objective' measures.

2) A focus on facilitating growth and the actualisation of potential, as opposed to a focus on treating pathology.

3) An orientation towards empowering clients, as opposed to empowerment as an adjunct to an absence of mental illness.

4) A commitment to a democratic, non-hierarchical client-therapist relationship, as opposed to a stance of therapist-as-expert.

5) An appreciation of the client as a unique being, as opposed to viewing the client as an instance of universal laws.

6) An understanding of the client as a socially and relationally-embedded being, including an awareness that the client may be experiencing discrimination and prejudice, as opposed to a wholly intrapsychic focus. (p. 120)

These principles describe a humanistic perspective of a client as a unique being, whose subjective experiences should be prioritised over a pathology of their mental health problems. An emphasis is placed on the client's unique experiences and reaction to them as the cause of psychological distress (Gillon, 2007). Furthermore, the therapy focuses on the client's own abilities and resources or self-actualising tendency to enable change to take place in a therapeutic environment. It has been suggested that CBT as an established disorder-specific treatment, associated with a medical model, does not share the same humanistic perspective (Blair, 2010). Gillon (2007) explains that this was possible because the first and second waves of CBT did not adequately consider the client's autonomy and aligned perfectly with the medical model in which the therapist is the healer and the expert and the client is the sufferer who needs to be treated.

This interpretation seemingly ignores the fact that Beck's (1979) seminal work describes warmth, accurate empathy, and genuineness as desirable characteristics in a therapist, influenced by Carl Rogers' (1957, 1961) humanistic, person-centred therapy (Dryden & Branch, 2012). Moreover, the inappropriate use of a therapist's power in CBT alluded to by Gillon (2007) is not unique to CBT, and can occur in other psychotherapies (Guggenbuhl-Craig, 1971). Hemmings (2008, p. 48) wrote that many CBT therapists approach their clinical work with the mantra that, "I have expertise in the model of CBT but I do not have

expertise in you – only you have that". In this view, a practitioner's expert knowledge of CBT does not define his or her position within the therapeutic relationship. The suggestion is that power imbalances in CBT only occur when it is done badly. For example, when a therapist 'imposes' an intervention such as behavioural activation on a client, the intervention becomes part of a therapist's personal agenda and not that of their client (Hemmings, 2008).

The link between CBT and the medical model was developed, however, as a political and pragmatic stance by its proponents, and the effect has been to maximise its use (Paul, 2010). Within this model, psychological disturbances are seen as specific disorders linked to patterns of thinking and are diagnosed, and the symptoms treated, in a structured-directive way (Gillon, 2007). The medical model, often thought of as synonymous with CBT, can be seen as a rationalistic and scientific approach that is at odds with humanistic values that stress the importance of relationships and shared creation of meaning (Blair, 2010).

Various positions exist within the field of counselling psychology as to the significance of using the medical model. While some have expressed concerns over the spread of medical model influence and its ideology in the NHS (Rizq, 2012), others have taken a more pragmatic stance and have encouraged counselling psychologists to work within medical model settings. Chwalisz (2003), writing from an American counselling psychology perspective, claimed that the profession's acceptance and assimilation of the medical model would actually enhance the profession's status within the healthcare system. In a rebuttal, Hage (2003) stated that a greater affiliation with the medical model would weaken the profession, because it would reject its humanistic identity. A third position, in which

counselling psychologists are encouraged to work within the medical model but to apply humanistic values in their clinical work has also been expressed (Frost, 2012; Milton, 2012).

Counselling psychologists' views about how to maintain a humanistic perspective of their clients when working in medical model settings vary between acceptance, rejection and cooperation.

3.1.3 The Therapeutic relationship

Up to 30% of the positive outcomes from psychotherapy have been attributed to the therapeutic relationship that exists between a therapist and their client (Lambert, 1992). The role of the therapeutic relationship is perhaps the most contentious topic regarding CBT and counselling psychology. A number of authors have stressed the importance of the therapeutic relationship and how the humanistic roots of counselling psychology are upheld through the collaborative nature in which therapeutic goals are prioritised and decisions made in CBT (Cooper & McLeod, 2011; Dryden, 2012). Others believe, however, that CBT has not and does not place adequate emphasis on this area (Richardson & Richards, 2005; Holmes, 2010). The therapeutic relationship has been defined in different ways across theoretical approaches. These perceived differences between CBT and other psychotherapeutic disciplines are much debated (Castonguay et al., 2010; House, 2010).

In 2012, Aaron Beck, then aged 92, provided background into the role of the therapeutic relationship in CBT (Annual Reviews, 2012). Beck recalled that in the 1950s, following training in psychoanalysis, he believed the therapeutic relationship was essential for change to occur. However, by the 1970s, he observed that clients improved because of the practical

solutions or CBT interventions implemented, regardless of whether or not the therapeutic relationship was central to their treatment. This led to the claim that the therapeutic relationship was 'necessary but not sufficient' for therapeutic change to occur (Beck, 1979).

Bordin's (1979) work on the 'working alliance' as a pan-theoretical concept was published in the same year as Beck's work on cognitive therapy for depression. The 'working alliance' has become synonymous with CBT, describing the importance of a client's successful learning of CBT through techniques or interventions or the 'work' facilitated by a collaborative relationship or 'alliance' with their therapist (Castonguay et al., 2010; Leichsenring et al., 2006). The working alliance comprises a 'bond' that exists between a therapist and a client which is reinforced through collaboration on 'tasks' and 'goals' (Bodin, 1979; Ekberg & LeCouteur, 2014; Kuyken, Padesky, & Dudley, 2011). It was later expanded by Dryden (2007) to include 'views'. These ensure that the importance of a shared understanding between client and therapist are brought into consideration concerning the nature of the client's problems; how they can be addressed; and the practical aspects of the therapy (Dryden, 2010).

In the last two decades others have also contributed to CBT's understanding of the role of the therapeutic relationship, inspired by psychoanalytic concept of 'transference' and 'countertransference' (Dryden, 2012; Jacob, 2004; Leah, 2008). This reconceptualisation has included 'addressing empathic failures' or 'ruptures in the therapeutic alliance' (Safran & Muran, 2000); and 'limited reparenting' (Young, Klosko, & Weishaar, 2003). CBT therapists have also been encouraged to develop greater self-awareness of their own

schemas so they may respond more effectively to their clients (Bennett-Levy & Thwaites 2007; Leah, 2008).

In spite of these innovations contemporary CBT literature commonly refers to the established concept of a 'working alliance' (Castonguay et al., 2010; Dobson & Dobson, 2009; Wills & Sanders, 2013). This likely reflects the reluctance of some CBT therapists to embrace concepts derived from psychoanalytic approaches (Dryden, 2012). Furthermore, it is possible that the efficacy of CBT via self-help books, in various computerised formats, and as a manualised treatment has strengthened the belief of some practitioners that it is the techniques and interventions of CBT, not the therapeutic relationship, that is the guiding force by which therapeutic change occurs (Bower, Richards, & Lovell, 2001; Annual Reviews, 2012).

The promotion of CBT in these delivery formats in which the therapist's role is either removed completely or largely reduced to empirically-grounded clinical interventions and specific techniques has led some to believe that CBT does not value adequately the therapeutic relationship (Richardson & Richards, 2005). However, proponents of CBT argue that the therapeutic relationship is more important for some clients than it is for others. For example, those with 'independent' personalities may require little to no support from a therapist, while the therapeutic relationship will likely be important for those with 'dependent' personalities (Annual Reviews, 2012; Dryden, 2012).

Opponents have attacked what they see as a lack of depth in CBT's conceptualisation of the therapeutic relationship. For example, Holmes (2010), writing from a psychoanalytical perspective, claimed that CBT appears to focus on a client's relationship with his or herself

and lacks therapeutic power. In his view psychoanalysis's understanding of the therapeutic relationship was better placed to explore clients' interpersonal, relational and intersubjective variants between themselves and others (Holmes, 2010). Loewenthal & House (2010) note that such criticisms often fail to gain traction with CBT's proponents as they could be seen to represent the voices of envious, disenfranchised therapeutic schools, which lack an evidence base for their therapies and whose time has passed.

However, criticism of CBT's approach to the therapeutic relationship is not confined to other schools but has also been expressed by counselling psychologists and other pluralistic practitioners. For example, Mearns and Cooper's (2005) work on relational depth in counselling and psychotherapy suggested that CBT techniques may make it difficult for therapists to interact profoundly with clients. Under such circumstances they suggest the therapeutic relationship would be less immediate and spontaneous because it is mediated by plans. The focus then is on doing something to the client rather than being with the person (Mearns and Cooper, 2005).

An alternative perspective on this issue can be found in the work of Judith Beck (2011), a leading authority in CBT, who advises that problem-solving through techniques and interventions should be used in a judicious manner by therapists. In certain situations their use is inappropriate, including when they impact negatively upon the therapeutic relationship where a therapist, "needs to step back, conceptualize the problem, and first repair the alliance" (Beck 2011, p.208).

Many perspectives exist, therefore, on the strengths and weaknesses of CBT's approach to the therapeutic relationship. While some support CBT's therapeutic relationship, others

believe that other theoretical approaches are superior. For example, Boucher (2010, p.166), an advocate of pluralism and a consultant Counselling Psychologist, has stated that "CBT is an arrow in my quiver, not my full crop (other theoretical models), and certainly not the bow (the therapeutic relationship)". From his personal experiences, Boucher (2010) cited the potential threat to the therapeutic relationship of working with manual-based treatments and protocols as counselling psychologists. This led Boucher to state that "the weight of power, influencing how their practice might be conducted in the consulting room, can often favour the demands of the therapeutic context" (Boucher 2010, p. 159). Concerns about how well counselling psychology's values are upheld within the NHS and IAPT settings have been widely commented upon (Cooper, 2009; Milton, 2010; Rizq, 2012; Strawbridge and Woolfe, 2010).

This theme was found in Mantica's (2011) IPA thesis that explored how the professional identity of qualified Counselling Psychologists was influenced by clinical experiences of CBT. The study found that the seven participants who worked with CBT in NHS and IAPT settings had found the experience of working with standardised protocols and high performance targets could constrain and place limits on their ability to be with their clients and was less authentic than other approaches.

It is possible, even likely, that the counselling psychology literature's portrayal of CBT's conceptualisation of the therapeutic relationship has under-reported what is actually recommended as being best practice from a CBT perspective and the notable developments that have been made in this area. However, there appears to be some uncertainty as to what exactly is CBT's contemporary conceptualisation of the therapeutic relationship and whether or not it incorporates PCT or PDT concepts (Levi, 2010). Given the importance of

the therapeutic relationship in counselling psychology, trainees' views about its role within CBT may understandably influence how they experience their work (Boucher, 2010).

3.2 The Theoretical orientation

Theoretical orientation or a therapist's preferred theoretical approach may play a role in how counselling psychologists experience CBT (Boucher, 2010; Mantica, 2011). It can be understood as part of a therapist's professional identity, separate from professional values, but also involving the integration of personal and professional identities (Bitar, Bean, & Bermudez 2007; Nelson & Jackson, 2003).

Across a wide range of psychotherapy professions therapeutic orientation is synonymous with the theoretical framework that enables a client's difficulties to be understood and treated and their practice to be described (Lyddon & Bradford, 1995; Vasco, Garcia-Marques & Dryden, 1993). Theoretical orientation is a significant personal and professional choice and there is a direct link between it and the approach to practice. The importance of a good fit between a therapist and his or her way of working has been stressed by numerous authors. A bad fit has been associated with a risk of job dissatisfaction and poor practice and is potentially detrimental to therapists' careers and the well-being of their clients (Fear and Woolfe 1999; Scragg, Bor & Watts, 1999).

It has been suggested that theoretical orientation is influenced by a therapist's personality and philosophy and contextual factors such as training, clinical experiences and job opportunities, and the complex interactions between them. However, for four decades theoretical orientation research from across the field of psychotherapy has focused predominantly on the idea that personality traits of therapists may predict their theoretical

orientation. Influential in shaping this early research was the work of Messer and Winokur (1980, 1984, 1986). They suggested (1980) that theoretical orientations held very different and often conflicting philosophical views about human nature. They also suggested psychoanalysis and first wave CBT were not just different but were in many ways incompatible. Their ideas about personality differences between therapists of different therapeutic schools have been influential in subsequent research. Studies have been extensively replicated in different population groups and countries using different personality and philosophical belief measures.

Scragg, Bor, and Watts's (1999) research using a personality styles test further elaborated on these insights. Their research (conducted with therapists on a postgraduate counselling course) looked at the differences between directive and non-directive counselling. They found that more directive models such as CBT were associated with assertiveness, systemisation, and conforming. Non-directive models such as the psychodynamic and person-centred were aligned with intuition, with therapists favouring unstructured therapy. These observations were supported by Arthur (2001) in a review of 45 studies on personality, epistemology and therapists' choice of theoretical orientation. Arthur concluded that psychodynamic therapists valued intuition, imagination, and theorising, whilst cognitive-behavioural therapists preferred conventionality and rationality. In 2003 a further study by Poznanski and McLennan with 103 Australian psychotherapists found evidence that psychodynamic therapists scored higher for neuroticism and openness. In comparison, cognitive behavioural therapists scored lowest for these traits.

Research by Buckman & Barker (2010) largely supported the findings of previous research. They conducted a survey on 142 trainee clinical psychologists in the UK using a

battery of tests used in previous studies to measure therapeutic orientation alongside personality traits and philosophical beliefs. This included the Therapeutic Orientation and Experiences Survey (TOES), Counsellor Theoretical Position Scale (CTPS), Organicism-Mechanism Paradigm Inventory (OMPI), and the NEO Five Factor Inventory (NEO-FFI). The research claimed support for previous findings on correlation between personality differences and theoretical orientation, including openness to experience being associated to a psychodynamic orientation and the opposite being associated with CBT (e.g. Poznanski & McLennan, 2004). Furthermore, consistent with Scragg et al (1999), a CBT orientation was associated with rational and objective beliefs whereas intuitive and subjective beliefs pointed towards psychodynamic therapy. However, Buckman & Barker (2010) did not support Poznanski and McLennan's (2003) evidence for differences between CBT and psychodynamic therapists' scores for neuroticism.

The link between a therapist's personality and chosen theoretical approach has dominated the literature on theoretical orientation. Other explanations for a therapist's theoretical orientation, for example, geographical location, professional setting, socio-political climate, and influence of a supervisor, have been afforded little consideration so far. Instead, such contextual factors which vary between individuals have been described as opportunistic or accidental factors, or even "the whims of fate" (Cummings and Lucchese, 1978 p. 323). Buckman & Barker (2010) attempted to address this imbalance by correlating the role of training with personality factors in a therapist's theoretical orientation. The findings demonstrated, in a sample of 142 trainee clinical psychologists, that training factors were also significantly correlated with a therapist's theoretical orientation.

All the therapeutic orientation research reviewed has been based on a realist ontology and objectivist epistemology. Theoretical orientation and other objects of study such as personality traits are understood to be universal and directly observable. This perspective has lent itself to quantitative methodological approaches that have attempted via questionnaires to capture a therapist's theoretical orientation and predictive variables, and to correlate the results. This statistical approach from a large number of studies, involving therapists from a wide range of contexts, has demonstrated strong correlations between personality factors and theoretical orientation.

In doing so, the research has implied a causal link between theoretical orientation and predictive variables such as personality traits, but does not prove it. Furthermore, by reducing the number of independent variables included in the investigations, it has over-simplified and exaggerated the link. Buckman & Barker's (2010) finding that training factors may also influence a therapist's theoretical orientation raises a question as to the relevance of personality traits in shaping theoretical orientation. Given the important role of CBT training for UK counselling psychology and the availability of CBT career opportunities, such contextual factors might be as important, if not more so, as personality traits in theoretical preference. Moreover, the researchers' participants were drawn from different social, cultural, and time periods, making direct comparisons between studies problematic, and the studies did not include counselling psychologists. Given the differences between counselling psychology and other professions in terms of professional values and training, it is uncertain to what extent these findings are applicable to the experiences of trainee counselling psychologists.

Notwithstanding the many limitations of these findings it seems possible that a therapist who believes in rationality and objectivity could be drawn instinctively to working with CBT, whereas a therapist who believes in intuition and subjectivity may be less inclined to do so. Although the exact mechanisms by which theoretical orientation is formed are unclear, it could play a significant role in how a therapist experiences his or her work (Boucher, 2010).

3.3 The research question, and aims

Although CBT is the dominant form of psychotherapy in the UK (Herbert & Forman, 2011); and plays an important role in counselling psychology training (Kahr, 1999), there is a general lack of literature on how trainee counselling psychologists' experience of their CBT placements. Placements are fundamental to trainees' professional development as the venue for applying theoretical knowledge and professional values in practice. With little empirical research on this topic, a wider literature base was used to explore how counselling psychology trainees may experience CBT placements including commentary, as well as quantitative and qualitative research consisting of a wide range of ontological and epistemological views. Two main themes emerged: professional values which have been researched from a relativist ontology and subjectivist epistemology, and theoretical orientation researched from a realist ontology and objectivity epistemology.

The subjectivist perspective suggested that counselling psychologists' interpretations of professional values such as pluralism, humanistic perspective of clients, and the therapeutic relationship vary greatly (Mantica 2011; Stapley 2014; Verling 2014). For some counselling psychologists in CBT settings, their perception of professional values may be a source of conflict if uncertainties are not resolved. While research from this subjectivist

perspective may have accentuated differences over similarities between participants, it also revealed a diversity of views about professional values, reflective of the commentary within the field.

The objectivist perspective in the research into theoretical orientation has suggested that a therapist's preference for CBT may be associated with their rational and objective beliefs (Scragg et al, 1999; Buckman & Barker 2010). A major limitation of this quantitative research has been the oversimplification and exaggeration of links between a therapist's preferred theoretical approach and the possible reasons for it. The theoretical orientation literature has not established causations and the causal link between predictive factors such as personality, training influences, and theoretical orientation has not been substantiated. Regardless of the reasons for a therapist's preferred therapeutic orientation, it could understandably influence their experience of CBT if it conflicts with the work they are doing.

All the studies have tended to group CBT experiences together, irrespective of epistemology, and specific details about the context of therapists' CBT experiences have been lacking. They have not distinguished sufficiently between different types of CBT, such as second or third wave, the length of therapy, type of clients treated, or other important differences. Arguably, they do not acknowledge the diverse group of treatments and contexts in which CBT is practised (McMain, et al., 2015) and provide the context in which qualified and trainee counselling psychologists may work.

The research question proposed is 'How do counselling psychology trainees experience their CBT placements?'. The question does not assume that the themes identified so far in

the review will be relevant to the contemporary context of trainees' experience of their CBT placements. Research to date has tended to focus on the experience of working in IAPT settings, but short-term CBT treatments are no longer limited to IAPT services and are used by other organisations in both the private and charitable sectors. Instead, it demands an original, open, and comprehensive investigation that embraces the inherent complexity of identifying influences. Such research could also make an original contribution by developing an understanding of what may be important themes within the experiences of trainee counselling psychologists' placements in CBT.

3.4 Counselling psychology relevance and potential application

The literature review has highlighted themes that may influence a therapist's experience of working with CBT: professional values and theoretical orientation. Inherent in this narrative is the potential for a therapist's positioning, in relation to these themes, to result in experiences that do not meet the expectations of a given CBT service. The research question reflects an interest in exploring whether these themes or others are relevant to the context of counselling psychology trainees' work in placements which is fundamental to their professional development.

A study that addresses the research question successfully will make an original contribution to the field of counselling psychology and its critical engagement with CBT. Specifically, it has the potential to help trainees, directly or via training staff, to understand how their own experiences of CBT might be influenced by certain factors. This could inform their reflexive practice by recognising how others have experienced their CBT placements as part of their professional training. Ultimately, exploration of these issues

could facilitate greater work satisfaction and indirectly improve the quality of CBT received by clients.

4. METHODOLOGY

The lack of research on counselling psychology trainees' experience of CBT placements favoured a qualitative methodology that could explore and interpret personal and contextual factors that may be relevant to the research question. Interpretative Phenomenological Analysis (IPA) was deemed the most appropriate method to accomplish this goal. Developed by Jonathan Smith in 1996, IPA is influenced by three philosophical fields of enquiry: phenomenology, hermeneutics, and idiography. These guide IPA's choices in data collection, interpretation and analysis (Smith, Flowers & Larkin, 2009). IPA was particularly useful for the study of trainees' experiences that are deeply embedded within the contemporary context of their training and the service provision of CBT in the UK. Informed by Smith's (2011) guidance on how to produce 'good' IPA research the methodology chapter explores these factors through a commitment to the theoretical principles of IPA, transparency in the analytical steps taken to provide a coherent, and the need to conduct a plausible and interesting analysis.

4.1 The rationale for IPA

Ontological and epistemological positions invariably inform methodological choices for research projects (Hesse-Biber & Leavy, 2010). Ontology can be defined as the study of being and existence and an attempt to discover the "fundamental categories of what exists" (Burr, 2003, p.203). Epistemology is the study of the "nature of knowledge and methods of obtaining it" (Burr, 2003, p.204).

Quantitative and qualitative methodologies bring philosophical positions (ontology and epistemology) together in a diverse range of perspectives and tools. An ontological position

of realism and an epistemological position of objectivism are often associated with quantitative methods in which a single truth of a given phenomenon is understood to exist and can be determined through appropriate research methods. Whilst quantitative methods have been used to establish correlations between personality traits and therapists' theoretical orientation, they may have oversimplified the relationship by ignoring other variables. The lack of research on counselling psychology trainees' experience of CBT placement favours a qualitative methodology that can explore and reveal personal or contextual factors that have not yet been discovered. In contrast to realism, qualitative methods have been associated with an ontological position of relativism and an epistemological position of subjectivism, which tends to replace the singular truth of realism with multiple realities.

However, there were several different qualitative methods to be considered, each with variations in relation to philosophical roots and theoretical assumptions, leading to differences in the type of research questions to be posed (Reicher, 2000). For example, grounded theory, developed by Glaser (1998, 2003) Corbin & Strauss (1998) and Charmaz (2006), was considered because of its ability to develop an explanatory theory of social processes, studied within their environmental contexts (Glaser & Strauss, 1967). It was rejected because developing a theory should not be the goal of research at this time. Essential exploratory research was needed to attempt to chart the territory. Only when more is known about the phenomenon under investigation and what specific social processes are involved would a grounded theory approach have the potential to develop a substantial theory.

Thematic analysis, a popular method to analyse classifications and related themes (Boyatzis 1998), was also considered. Thematic analysis has been described as a versatile research method, not a research methodology, because unlike other qualitative research methods it holds no fixed epistemological or ontological positions (Braun & Clarke, 2006). In contrast to thematic analysis, IPA has an established methodology with specific ontological and epistemological claims in the areas of phenomenology, hermeneutics, and idiography. The relevance of these concepts to the study made IPA a better choice than thematic analysis to answer the research question.

Phenomenology, associated with Husserl (1859-1938), is a philosophical movement about the study of experience and the ways in which things (phenomena) present themselves in and through experience (Finlay, 2014). It stresses the importance of understanding a participant's lifeworld in which a given phenomenon is embedded and the social, political, cultural, temporal context in which it is immersed (Frost, 2011). This was particularly pertinent to the study of trainees' experiences which are understood to be deeply embedded within the contemporary context of their training and the service provision of CBT in the UK.

Hermeneutics, associated with the work of Heidegger, claims that phenomena are always mediated by interpretation, and has been influential in shaping IPA. This includes an acknowledgment of a "double hermeneutic" in which the researcher is "trying to make sense of the participant trying to make sense of what is happening to them" (Smith et al., 2009, p.10). As a trainee counselling psychologist my personal views, attitudes and beliefs are likely to impact the research. IPA's insights into the double hermeneutic acknowledges research bias and the importance of being aware how this can impact the research.

Ultimately, this process provided greater transparency, accountability, and deeper levels of interpretation in the research.

Idiography is a tradition of exploring subjective accounts in detail and depth within their given context, and developing a deep understanding of individual cases before any generalisations are made. It provides a bottom-up and not a top-down approach. Idiographic sensibility is a key component of the IPA method (Smith et al., 2009). The focus on studying individual accounts in depth is fundamental to this research. In doing so, it gives voice to the experience of CBT placements by counselling psychology trainees.

IPA is also a powerful interpretative method with a focus on content, systematic analysis, and discursive constructs. It shares similarities with other approaches such as narrative analysis and discourse analysis but is not constrained by one method of analysis (Frost, 2011; Willig, 2001). IPA's ability to draw upon different analytical styles and its epistemological insights made it a research methodology that was well placed to develop an understanding of counselling psychology trainees' experiences of their CBT placements as they were presented and not as they were predicted or hypothesised.

IPA's interest in individual subjective accounts helped to avoid overgeneralised interpretations by giving voice to each trainee's unique experiences and understandings. The double hermeneutic in IPA did not hide the potential impact of my subjectivity within the research process. Instead, it acknowledged it and made the process by which my own subjective experiences (understandings, feelings and experiences) as a counselling psychologist trainee informed my interpretation of the data, making this as transparent as

possible for the reader. In deciding to use IPA, a mixed methods approach was considered. Smith et al., (2009) notes that IPA, when combined with quantitative approaches in a mixed method approach, can increase insights and leverage. Having considered it carefully an IPA approach that used only semi-structured interviews was chosen as the best way to uncover attitudes, opinions and specific situational contexts presented by participants without unduly biasing the results. In the future, quantitative methods may prove useful as a way to verify the research findings but the groundwork needed to be completed first.

4.2. Sampling/ Participants

Consistent with the IPA methodology a sample of the target population was selected through inclusion and exclusion criteria. Sample specificity is essential to the IPA research process and is related to an IPA's ability to provide insights and relevance to others through its theoretical transferability (Smith et al., 2009). The idiographic nature of IPA studies demands in-depth analysis of a particular phenomenon in its context on an individual level and not just on a group level. In this respect, less is more when it comes to sample size as analysis needs to be systematic and comprehensive (Smith et al., 2009). Homogeneity of the sample in turn provides an opportunity to examine in detail psychological variability within the group, through analysis of convergence and divergence (Smith et al., 2009). The research population is well defined as trainee counselling psychologists currently on training courses in the UK. As Smith et al., (2009) note factors important for sample homogeneity will vary between projects depending upon the particular research focus.

The possibility of restricting the sample to participants who had worked in IAPT services was considered, positioning the research within some existing commentary. However,

codifying and standardising of CBT by organisations is not restricted to IAPT (Chapman, 2012). Instead they are pervasive in the contemporary cultural, political and economic climate within which second wave CBT services are being delivered (Fairfax, 2008; Reynolds & McKee, 2012). Essentially, the phenomenon under investigation was how trainees experience their CBT placements in its many settings and how they reflected on CBT experiences as part of their personal and professional development. It was not desirable, therefore, to limit the scope of the investigation to one type of clinical setting. The sampling strategy drew upon participants with experiences which might or might not have included placements within the public, private or charitable sectors.

4.2.1 Inclusion and exclusion criteria

To increase homogeneity of the sample and its relevance to the research question, two inclusion criteria were set:-

1. That participants have experience of at least two second wave CBT placements

The inclusion of second wave CBT experience was chosen as the research is interested in how CBT is predominantly taught and currently being experienced during trainees' clinical placements. In spite of an increased popularity of third wave CBT it has not yet achieved the mainstream recognition of second wave CBT. Second wave still dominates the provision of psychological interventions as recommended by NICE and was likely to be the model of CBT primarily taught to trainees by their course providers. Third wave CBT has also been described as a significant departure from the theoretical ideas of second wave CBT (Winter, 2008). A study that included third wave CBT may only reveal general differences between these approaches. The selection of trainees with experience of at least

two second wave placements added depth to the participants' ability to reflect critically on their experiences of how CBT was delivered in different clinical settings.

2. That participants are currently in their final year of training.

During training counselling psychologists undergo stages of development as they move from being novices to emerging professionals (Rizq, 2006). The inclusion of final year trainees, nearing the end of their journey to professional status as counselling psychologists, meant they would be in a superior position to reflect critically on their second wave experiences as part of their personal and professional development.

Smith et al., (2009) notes that it is only possible to do the detailed, nuanced analysis associated with IPA on a small sample. As IPA is a time intensive-research method with an emphasis on studying each participant's experiences in depth it has been recommended for professional doctorates to conduct between four and ten interviews (Smith et al., 2009). Thus, eight interviews were undertaken in total, with two pilot interviews used to refine the interview schedule (Appendix A).

4.2.2 Recruitment strategy

Prior to recruitment of participants, the study had obtained approval from the London Metropolitan Ethics Committee.

The recruitment strategy included making initial contact with course administrators and directors of professional doctorate programmes in counselling psychology in the UK, with a request to circulate the information sheet (Appendix B). Most universities offered their support and helped to disseminate the information sheet to their students via email.

However, several universities had a policy that prohibited the forwarding of email enquiries to their students due to the large number of research enquiries they receive. Instead they agreed to post the information sheet on their department notice boards. Final year trainees who expressed an interest in participating were asked to email the researcher to arrange an interview. The researcher then informed the participants of the nature of the study and a convenient time was arranged for their participation in an interview.

Participants were invited to interview at the London Metropolitan University with any travel costs being reimbursed by the researcher or the researcher would make arrangements to meet participants at their own university. Skype was also offered as a means to interview. It proved popular, as all of the participants chose this option. The interviews lasted for approximately one hour and were conducted between December 2016 and February 2017.

4.2.3 Self-selection

The first six participants who expressed an interest in the research and met the inclusion and exclusion criteria were interviewed. While CBT is taught as a primary model by five courses and a secondary model by seven courses, all six participants in this study represented courses that taught CBT as a secondary rather than a primary model. This was likely a consequence of both the recruitment process and possibly self-selection bias. A number of the universities that taught CBT as secondary model disseminated the information sheet before those that taught CBT as a primary model. Thus, their students had the first opportunity to respond. However, the overall response rates suggests that the research topic may have also appealed more to students who had been taught CBT as a secondary model. It seems that trainees from such courses were more motivated to

participate in the study having learnt person-centred therapy or psychodynamic therapy as an alternative to CBT. In this respect, they were perhaps more inclined to participate in interviews to express or explore their critical thoughts and opinions about CBT, while trainees taught CBT as a primary model may have had less incentive to participate in this direction and may not have expressed the same level of concerns about working with CBT. The extent to which the participants were representative of opinions among trainees across the board is considered when interpreting the findings (see section 5.1 'reflections on the analysis') and in the discussion.

4.2.3 Participants demographics and training in CBT

In total, six final year counselling psychology trainees participated in the research. All six participants were women. Further demographic information including information about their training in CBT is provided in Table 1.

Table 1. Participants' demographics and training in CBT

Pseudonym	Age range	Number of CBT placements	Primary Model taught by course*	Prior clinical experience in CBT
Amy	45-55	2	PCT	>4 years
Becky	45-55	2	PDT	-
Christine	25-35	2	PDT	2 years
Danielle	25-35	4	PCT	-
Ellie	35-45	2	PCT	-
Fiona	25-35	3	PCT	-

** PCT = person-centred therapy, PDT = psychodynamic therapy*

The sample represented participants from four different counselling psychology courses in the UK. All of these courses taught PCT or PDT as a primary model, with CBT being

taught as a secondary model. On average the participants had worked with CBT as a stand-alone approach in two placements. Their courses also provide guidance on the use of integrative approaches, which the participants had experience of using in at least one other placement.

Collectively, they had worked in a wide variety of settings including: a forensic counselling service, eating disorder services, and IAPT services within the public sector; domestic violence, drug and alcohol, and community mental health services within the charitable sector; school and university counselling services and an acute mental health care service within the private sector.

4.3 Data Collection

IPA studies have been conducted using a variety of methods such as focus groups, participant observations, and diaries.

4.3.1 Semi-structured interviews

Semi-structured interviews were used in this research as they provided an opportunity to uncover the stories, thoughts and feelings of participants and their experiences of CBT placements. This was described by Smith et al. (2009), who also noted that these interviews permit an intimate focus on a person's experiences through in-depth and personal discussion, and are thus optimal for most IPA studies. Semi-structured interviews facilitate consistency of questions between participants whilst providing them with space to think, speak and be heard (Smith et al., 2009).

The primary purpose of the interview schedule was to provide participants with an opportunity to talk about their experiences with minimal interruption from the interviewer

(Smith et al., 2009). In order to achieve this, the interview schedule (Appendix A) was put to the test in a pilot study with two students from my course. The first question was chosen to allow the participant to provide a descriptive account of their different placements, with subsequent questions being chosen to cover potential influences on their experiences such as supervision and professional identity as well as those relating to their evaluation and perceptions of CBT as an approach. The interview questions proved successful in the pilot study, providing the participants with both time and space to recall their experiences and to express their thoughts about CBT.

These questions were designed to be open and expansive so as not to lead them to a particular answer or to make assumptions about their experience or concerns (Smith et al., 2009). Questions that were over-empathetic, manipulative, leading or closed were avoided. Instead, following guidance in Smith et al., (2009), questions that were descriptive, narrative, structural, contrasting, evaluative, circular or comparative in nature were used, with the use of additional prompts and probes. In line with this guidance Question 6, "How have your experiences as counselling psychology trainee shaped your views about CBT as a theoretical model?" was reworded following the pilot study to, "How do you view your CBT work as a counselling psychology trainee?". The original wording of the question was found to be both confusing and leading, interrupting the flow of the interview by requiring clarification from the interviewer.

These interview questions used in the study proved effective in facilitating the participants' thoughts and feelings. However, it was observed in the findings that significant overlap exists between these questions and the study's IPA themes. It seems likely that the

questions themselves guided the participants to discuss specific topics. This is explored further in the limitations section of the discussion chapter.

4.3.2 Skype

Skype is a VoIP (Voice over Internet Protocol) technology, acquired by the Microsoft Corporation in 2011, which offers free communication over the internet. It has proven to be an effective method for conducting interviews because it overcomes logistical, financial, and time-commitment barriers that attendance at interviews in person may pose (Cater, 2011; Deakin & Wakefield, 2013; Iacono, Symonds, & Brown, 2016). All of the research participants took advantage of Skype. It proved popular as it made allowances for the competing demands on their time from work-based placements, attendance at university, and working on their own dissertations. It also gave easy access to participants across the UK that would not have been possible without it.

Establishing rapport and observing non-verbal communication are important factors in successful face-to-face interviews (Brinkmann & Kvale, 2005; Rowley, 2012). It has been suggested that these elements may be poorly replicated with Skype because non-verbal communication may be limited (Cater, 2011) but there is a growing consensus that these fears are unfounded (Sullivan, 2012). Facial expressions provided by Skype's video function give valuable non-verbal communication and it allows more attention to be paid to audible cues (Seitz, 2015). Participants are able to pick a comfortable environment, are not required to travel a long distance to an unknown location, and are able to talk openly (Hanna, 2012). These factors mean that rapport may be established faster (Deakin and Wakefield, 2013).

In this study, the participants appreciated having the option to use Skype, and they chose to interview in the comfort of their homes, having allocated time in their schedules when they would not be disturbed or distracted. This supports Hanna's (2012) observation that participants can feel confortable when using Skype in a place and at a time of their choosing. As final year counselling psychology trainees, the researcher and the participants also shared an identity which provided common ground through which to explore the research topic. All of these factors helped rapport to be established between the participants and the researcher, evident in the participants' free expression of their thoughts, feelings, and opinions during the interviews. Under such conditions this study supports the general conclusion of Deakin and Wakefield (2013) that Skype can be an effective medium by which to establish rapport.

As with any IT equipment technical faults can occur with Skype. To mitigate the risk of interruption, the participants were asked to find a location with a reliable internet connection. While no technical problems occurred, the participants had been forewarned that a poor connection (audio or video) would be unsuitable for later transcription and analysis. If there had been an interruption the interview would have been suspended until a better connection was established or rescheduled. The participants were also informed about limitation of confidentiality. The Skype user's agreement states that the content of users' emails, chats, or video calls will remain private but there are limits to confidentiality if a request for access is made by law enforcement authorities (Microsoft, 2016). Before the interview, participants were asked to complete and sign consent and demographic forms by email or through the post.

4.5 Data Analysis

Interviews were transcribed verbatim including pauses from the audio-recordings. The resulting transcripts were then analysed using six analytical steps outlined by Smith et al., (2009). Although these steps are suggestions, and more advanced IPA researchers may deviate from them, they provide an analytical framework to help improve the quality of the research.

4.5.1 Analytical Steps

As outlined in Smith et al., (2009), the following steps were followed:

Step 1. Reading and re-reading

The original transcripts and audio recordings were studied in depth to ascertain what the participant was saying while resisting quick judgements and interpretations. The overall structure of the transcript was identified, including chronological accounts, shifts from generic to specific events, and sections that contained richer and more detailed material.

Step 2. Initial noting

Each line of the transcript was examined for its semantic content. During this step, the right hand margin was used to annotate the transcripts to make descriptive, interpretive, linguistic and conceptual comments. Descriptive comments covered objects that were of concern to the participants and the aspect that was a particular cause of concern. Interpretive noting explored how and why participants had these concerns. Linguistic comments picked up points of interest in the use of language such as certain phrases, laughter, and metaphors, while conceptual comments were used to make sense of participants' patterns of meaning.

Step 3. Developing emergent themes

During this step, Microsoft's Excel programme was used to collate the data from step 2 for purposes of clarity, enabling the emerging themes to be compared more easily with the initial notes and original text. These emerging themes mapped interrelationships, connections and patterns that moved to more abstract or conceptual ways of understanding. An illustration of how the IPA steps were taken through 1 to 3 is provided in Appendix C with extracts from each of the participants' transcripts.

Step 4. Searching for connections across emergent themes

The database thus created was then used to examine the emerging themes. Excel's 'sort' and 'filter' functions were used to explore lists of themes for each participant, supporting the techniques for searching for connections, outlined in more depth by Smith et al (2009) which included abstraction, subsumption, contextualisation, numeration, and function. During this step patterns of interest and potentially important aspects of the participant's accounts started to emerge; and they were then added to the database.

Step 5. Moving to the next case

After the first transcript was analysed, the previous steps were repeated for each subsequent transcript. This was in keeping with the idiographic commitment of IPA in which each participant's transcript is treated on its own terms and ideas that have emerged from previous analysis are bracketed off as much as possible.

Step 6. Looking for patterns across cases

Excel was used to amalgamate the participants' emergent themes and to seek connections through the identification of higher order concepts which were then compared to the emergent themes and to the original text from which they originated. While the super-ordinate themes were embedded in each of the participant's idiosyncratic accounts, this

step revealed common themes of interest across their cases. A list of themes can be found in Appendix D. These themes were then consolidated further and presented in the findings.

4.6 Ethical Considerations

The British Psychological Society (BPS) Code of Ethics and Conduct (2009) and the BPS Code of Human Research Ethics (2014), principles of respect and guidance on risk assessment, valid consent, and confidentiality were applied to this research.

These included a respect for participants' cultural and individual differences such as sexuality, disability, and ethnicity. No individual was discriminated against in any way. Respect also included recognition of participants' rights to privacy, self-determination, personal liberty and natural justice. Participants were asked to consent freely to participate on the basis of having received adequate information in advance. The information sheet also covered issues of confidentiality (and limitations to it) and anonymity, data security, and rights to withdraw from the study (see Appendix D). Informed consent was sought in writing before any audio-recording or interview began, the form used can be found in Appendix E. Participants were told verbally and in writing through an information sheet about the nature of the study.

A participant's personal information such as their name, age, contact details and other identifiable information were kept separate from audio recordings and held securely. Audio-recordings were stored on a computer folder that was password-protected in line with the Data Protection Act (2012) and BPS guidance (2014). Paper consent and demographic forms containing personal information were stored in a locked, secure safe

box. The form used to collect demographic, and CBT experience, information can be found in Appendix F. Identifiable information such as participants' names, specific details of placements and cases discussed were removed from the written report in order to protect the anonymity of participants and others who might be mentioned in the interview process.

Following BPS guidance (2014) participants were informed that they had the right to withdraw from the study, without questioning by the researcher or the need for an explanation, before or during the interview and that any recorded information or audio data would be destroyed. After the interviews participants were also afforded the same right to withdraw, up to the date when their data had been analysed. This cut-off point was deemed necessary to protect the integrity of the study and the researcher's ability to meet deadlines, while still allowing participants time to withdraw from the study after the interview had been conducted. At a further safeguarding all stored data will only be kept as long as necessary (a maximum of five years for the purpose of publication) and will then be destroyed.

Although the research topic did not cover a subject deemed sensitive by the BPS (2014) it required participants to discuss their private thoughts and feelings. No participants reported distress, but they were told at the time that they could pause or stop the interview at anytime. The researcher had also provided possible sources of support in the debriefing sheet (see Appendix G). Participants were also offered time at the end of the interview to reflect on the process and to be debriefed about the research processes.

4.7 Issues of credibility/ trustworthiness

It has been suggested that the concepts of 'reliability' and 'validity' are rooted in a positivist perspective commonly associated with quantitative methodologies (Golafshani, 2003). In quantitative research reliability can be established if the same findings are found when repeating the study and validity, commonly associated with the experimental design, is a quality control test that asks whether the finding fairly reflects the variable it set out to measure.

IPA, as a qualitative research methodology, does not predict outcomes and 'replicability' may not be possible due to its interest in the subjective, contextualised, and temporal accounts of participants. While 'reliability' and 'validity' are used to assess the quality of qualitative research, the emphasis is on the 'dependability' and 'consistency' of data collection and analysis, not on the replicability or generalisability of its findings (Golafshani, 2003). It is important, therefore, that qualitative researchers demonstrate 'quality', 'transparency', 'commitment', and 'rigour' in the methodological process they use so that its findings may be seen as credible and trustworthy, and thus be of potential value to others (Smith, 2011; Yardley, 2000).

Some commentators have suggested an invitation to participant to review interview transcripts and emergent themes can act as a validity measure in IPA by ensuring greater accuracy in the representation of the participants' words, expressions, and thoughts (Smith et al., 1996). In this study, however, such a review was not possible as the participants chose not to contribute further after their interviews because of commitments to their own research, academic studies, and clinical work.

Steps were, nevertheless, taken to address validity through other measures, including learning and practising the IPA methodology by reviewing published IPA studies, the Yahoo forum for IPA analysis, guidance by Smith et al., (2009), and IPA tuition provided by my course prior to commencing the study. During the study, excerpts of my preliminary analysis were shared with two counselling psychology doctorate trainees on my course. These trainees were conducting their own IPA studies and this peer review process helped to verify that appropriate analytical steps were being followed. The peer review also provided an opportunity to gather their perspectives on the emerging themes taking into account our unique experiences and differing interpretations of the underlying data. In the event the themes were largely consistent between us. Finally, having completed my initial analysis, the emerging superordinate and subordinate themes were reviewed and refined under academic supervision to ensure that they conveyed as clearly as possible the meaning of the themes as well as having descriptive power.

For purposes of transparency, granular details of the methodological process used are available for review (see Appendices A, C, D & H). Finally, in terms of commitment, time was taken to follow closely the analytical steps outlined by Smith et al., (2009), with the analysis being conducted over a three-month period. This allowed significant time to be spent on each of the participant's transcripts before searching for possible patterns and connections between them.

5. FINDINGS

This chapter provides my reflections on the analysis and presents the findings displayed both as a master table and in a narrative format. The tables provide an overview of the major themes emerging form the IPA analysis and their respective sub-themes while the narrative section offers extracts from the participants' interviews alongside my interpretation of their significance and meaning.

5.1 Reflections on the analysis

This IPA study followed the methodological guidance provided by Smith et al. (1999). At first this included reading, and re-reading, the participants' interview transcripts before noting any descriptive, linguistic or conceptual meanings that emerged from their accounts. This process produced a large number of preliminary themes for the first participant. Attempts were then made to 'bracket' these themes so as not to presuppose their relevance to other participants (Smith et al., 2009). Such bracketing helped me to keep an open mind when engaging with the participants' accounts on a case-by-case basis. It also ensured that the emerging themes were grounded in their individual accounts.

The later stages of the analysis necessitated that the thoughts, opinions, and beliefs revealed in the emerging themes were interpreted to enable connections between participants to be established. A researcher is expected to use his or her knowledge to interrogate such 'meanings that come to be' in the analysis (Finlay, 2008). Nevertheless, I was aware that there were often significant differences between the participants' accounts and my personal experiences of the same phenomenon and that these were salient to how I interpreted their experiences.

It became clear that my course had focused on CBT as its primary model, whereas the participants had all been taught CBT as a secondary model. On average, the participants had used CBT as a stand-alone approach in two placements with few experiences of working 'in-house' with counselling psychology supervisors. They had also experienced at least one additional placement where they delivered CBT as part of an integrative approach. In comparison, I had worked in five CBT placements, the vast majority of which included counselling psychology supervision. These supervisors encouraged my exploration of multi-theoretical insights and techniques, notably those concerned with understanding and developing therapeutic relationships with my clients, and I perceived these additions to be part of a CBT approach. In comparison, many of the participants believed that, on the basis of their experiences, such 'integration' was not possible in CBT placements.

In my experience, CBT has proven itself to be a versatile and effective model of therapy. Furthermore, because I was able to use insights or techniques from other therapeutic schools of thought, I perceived that my counselling psychology values such as pluralism and the saliency of the therapeutic relationship were being upheld in my work. However, many of the participants had not been afforded the same opportunity within their CBT placements, and they held a more critical stance towards CBT's value.

These differences in experiences and opinions about CBT are explored in the findings through my interpretation of the participants' accounts. They are especially significant when I interrogate the assumptions and inferences behind the participants' claims that CBT is not compatible with their counselling psychology values. Direct quotes from the participants are italicised in the findings to distinguish them from my interpretation. The

intention is to enable the reader to evaluate the contribution made by the researcher in the derivation of knowledge presented in this chapter.

5.2 Themes

Three superordinate themes each containing three subthemes, emerged from the analysis. Theme 1 is 'Pure CBT vs. integration' and explores the importance of the different experiences where the participants practiced CBT as a stand-alone approach and as part of an integration approach. Theme 2 is 'CBT conflicts with counselling psychology's values'. It explores how the participants' interpretation and belief in professional values influenced their perceptions and evaluations of CBT. Theme 3 is 'Deconstructing & assimilating CBT' it flows from the participants' placement experiences and explores how they hoped to integrate elements of CBT with PCT or PDT, reflecting their interest in CBT's techniques rather than in its approach.

Each superordinate theme and its related subordinate themes provides a different theoretical or explanatory focus and offers additional insight into how the participants experienced working with CBT as a whole. Significant overlap and interconnectivity exists between these themes reflecting the fact that the participants' placement experiences were informed by and in turn shaped their perceptions and evaluations of CBT. Thus, the participants' experiences of working with CBT explored in Theme 1 are intrinsically connected to how they evaluate CBT as an approach explored in Theme 3. In turn, these themes can be understood to relate to the participants' interpretation and belief in professional values explored in Theme 2. The interconnectivity between themes is noted in the findings and explored further in the discussion chapter.

Table 2 provides a summary of the superordinate and subordinate themes emerging from the IPA analysis. An extended version of the table including more sample quotations from each participant can be found in Appendix H.

Table 2. Abbreviated Master Table of Themes

Superordinate Theme	Subordinate Theme	Sample quotation
Theme 1 Pure CBT vs. integration	a. Learning CBT where it is practised	(It's) really important to learn the skills of CBT in an environment where just that is practised (Ellie: 413-414)
	b. Use CBT and nothing else	You get a bit frustrated (with CBT) you can see the limitations (Christine: 36-40)
	c. No set approach to be followed	CBT is very much used in a kind of cherry picking-type way, so psychologists use the bits that they think will suit that client rather than to just a set protocol, one size fits everybody (Ellie: 151-153).
Theme 2 CBT conflicts with counselling psychology's values	a. CBT sits alongside other therapies	I approach CBT as another tool, rather than kind of the central tool that I use (Fiona: 383-384) - pluralism
	b. First the relationship, then CBT	I think it's about building a relationship and then using some of the CBT, you know (Ellie: 372-373).
	c. CBT oversimplifies problems	CBT formulations can be fine, but with really severe presentations I don't think it...goes anywhere near enough to explaining them (Fiona: 402-404).
Theme 3 Deconstructing & assimilating CBT	a. CBT provides structure and permission to challenge	There is something about being able to put structure on things for someone who feels that they've no structure (Fiona: 287-290)
	b. CBT's focus is both its strength and its weakness	(CBT) doesn't necessarily always create space for the nuances (...) CBT is like nope, we're here to talk about your depression (only) (Amy: 638-642).
	c. Assimilating CBT	I find that I'm always bringing in CBT techniques regardless of the approach I take (Becky: 555).

5.2.1 Theme 1: Pure CBT vs. integration

The participants consisted of six final year trainees with experience of working in at least two CBT placements recruited from four counselling psychology courses in the UK. All of their courses taught CBT as a secondary rather than a primary model, and they were expected to demonstrate a 'working knowledge' of CBT, defined as the ability to apply theory into therapeutic practice by the end of the training (BPS, 2014). The focus of the research was on how trainees experienced working with CBT as second wave approach in their placements. The analysis showed that all the participants had also worked with CBT as part of an integration approach in at least one other placement. Their positive experiences of integration were often juxtaposed with negative experiences of working with CBT as a stand-alone approach.

Theme 1a: Learning CBT where it is practised

The impact of prior clinical experience had not been adequately considered in advance as an influence on how trainees could experience the research phenomenon (see Chapter 5 for a discussion of the study's limitations). Nevertheless, there was sufficient data to explore the relationship between the participants' experience of CBT placements and their level of confidence in using CBT theory in practice. This revealed that placements where they worked with CBT as a stand-alone approach provided an optimal venue to develop their working knowledge of and confidence in working with CBT, especially for four of the six participants who started their training as CBT-novices. They offered learning opportunities that appeared to compensate for a perceived lack of CBT content on the participants' courses.

As an example, Becky undertook two CBT placements within the charitable sector during the second and third year of her course. These were a domestic violence service and a drug and alcohol service, which used specific-disorder models of CBT. Becky had recently applied for another placement that would require her to use CBT for a wider range of presenting problems than she had worked with in her previous placements. Faced with this she said:

> *I sometimes feel that I'm still behind in my CBT approach, that (...) I'm still learning a lot of CBT because I think (my course) didn't cover it as much as I would (have liked) (B:619-620).*

Here, Becky seems to imply a causal link between the amount of training received on her course and her current CBT knowledge. From her perspective the course had not been able to provide her with the level of knowledge she felt was needed, which she seemed to attribute to the fact that CBT was taught alongside psychodynamic therapy.

> *When I speak to (...) CBT therapists, that have done CBT only, I...I just feel I've got so much to learn (...) By us trying to cover psychodynamic and CBT, I just feel that we're just really touching the surface (B: 636-641).*

In comparing herself to 'CBT therapists' it should be noted that she had received supervision from an experienced CBT therapist in a previous placement, and she felt significant further study would be required if she were to achieve an equivalent level of knowledge. Given her supervisor's seniority Becky probably did not expect to achieve this during her counselling psychology training and the comparison could simply have reflected her anxiety about her preparedness to work in a new CBT placement.

However, Christine - who attended the same course - provided additional information. She said:

...(the) course is generally very psychodynamic. But I know in (the) first year it just really taught CBT just as a bit of a core model, then it did psychodynamic (C: 62-64).

Her description of the course as ‘very psychodynamic', adding that it taught CBT as 'a bit of a core model', may imply that the curriculum’s focus was on psychodynamic therapy, and not CBT. This interpretation helps to explain why Becky, and many of the participants who started their training as CBT-novices, believed that CBT taught as a secondary model had not provided them with enough training in its theory or its practical clinical skills. While this course structure seemed to complement the learning needs of trainees like Christine, who had previous knowledge of CBT, it meant that those like Becky who did not have such prior experience faced steeper learning curves to build their confidence to work with CBT.

Amy, like Christine, had worked with CBT for several years before undertaking the course and likely possessed a working knowledge (and possibly an expert knowledge) of CBT when she started her course. She said:

It's just not a particularly well-scaffolded training in CBT. (..) it's very rudimentary, very basic and doesn't (give a) full spectrum of CBT (...) that I would like to see anyway (A: 396-399).

With the use of phrases such as 'very basic', 'not full spectrum' and ‘not a particularly well-scaffolded training’, Amy appears to suggest strongly that the course’s CBT curriculum was inadequate. The quality of the CBT taught on her course was a theme that she returned to several times during the interview. It was not explicitly clear why this was a significant concern for her personally, given her previous training in CBT, but her prior knowledge

likely drew her attention to its perceived shortcomings. Currently a lack of granular detail about how courses teach CBT means that it is not possible to verify such claims but Amy's account raises doubts over how well CBT learning for a novice like Becky was supported by their courses.

Notwithstanding these issues, the participants' accounts showed that in the majority of cases CBT placements, alongside independent study, helped them to develop confidence to use CBT. Ellie, for example, had not worked with CBT before and initially lacked the confidence to use it. However, this changed after working for an IAPT placement in her second year. She acknowledged during the interview that without the placement she would probably not have gained the confidence on her course to practise CBT. When reflecting on this, she suggested that others could benefit from undertaking a similar placement. Ellie said:

> *...(It's) really important to learn the skills of CBT in an environment where just that is practised because (...) if you're not learning the CBT kind of properly, (...) then I'm not sure that you can ever really fully make a decision about how it fits into practice (E: 414- 419).*

Ellie's placement supervisor in an IAPT service had instructed her only to use CBT theory (see Ellie's statement in Theme 1b) which helps to explain why she felt it was a 'proper' way to learn CBT; insights or techniques from other theoretical approaches were not used in her placement. For a CBT novice it appears that this had proven itself to be an effective way to learn CBT. However, the use of 'kind of' when describing the importance of learning CBT in this manner appears as a qualifier introducing an element of doubt as to whether Ellie truly believed this statement. This relates to the interpretation of Ellie's statements explored in Theme 3.

Like Ellie, Fiona had initially been reluctant to undertake a CBT placement and only did so in her second year with an IAPT service. She said:

> *I think if I didn't have that placement, I wouldn't be competent in my CBT at all (F: 188-189). I've been pretty lucky. I probably could have ended up just not being competent in CBT and not really liking it very much (F: 490-491).*

Again like Ellie, Fiona acknowledged the positive impact the placement had had on her professional development, but she made a more definitive statement about the significance of the placement for her competence in CBT. She also introduced the idea that the placement had challenged preconceived views about the merits of using CBT. However, 'pretty lucky', conveys the message that the professional development opportunity afforded by Fiona's placement was subject to chance. It is fair to say that these placements were transformative for both Ellie's and Fiona's sense of confidence and competence to work with CBT. Given the importance of placements as the opportunity to learn how to apply CBT theory into practice, it raises questions about whether or not they were given sufficient encouragement and support to move in this direction.

Theme 1b: Use CBT and nothing else

Clinical supervision is an integral part of counselling psychology trainees' continued professional development. Supervisors also ensure their work is in line with the placement's organisational procedures and policies. When the participants were asked about their supervision, they typically recalled negative experiences associated with their supervisor's role in enforcing a placement's procedures and policies which they saw as unhelpful and sometimes as a hindrance to addressing fully their clients' problems. This included adherence to an approach to CBT that they felt ignored insights from other

approaches and working with a limited number of sessions. In these situations they had often found themselves at odds with how their supervisors expected them to work in their placements. This led participants to express ambivalence towards CBT, in spite of their positive experience of working with CBT (explored in Theme 3a).

Ellie, for example, described a negative experience of supervision during her IAPT placement. She explained:

> *…the supervision was very much, "You will just use CBT and nothing else."…if therapy wasn't working for that person, then there wasn't anything else offered and that felt really restrictive … (E: 98-101).*

Ellie's description of how she saw her supervisor's insistence on using 'CBT and nothing else' as a rigid position that restricted unduly her ability to use other approaches illustrates her concerns that service users are restricted in their ability to access alternative therapies. CBT is currently recommended by NICE as best practice and consequently mental health services such as IAPT use CBT as their treatment of choice for most of the common mental health problems. From Ellie's perspective, however, it appeared that PCT's approach to the therapeutic relationship could also contribute to her work (see Theme 3b). This helps to explain why she felt the placement and her supervisor placed too much emphasis on using CBT. In turn, her perception that other services delivered CBT in the same way meant this critique was not only attributed to this placement but to its general use. This interpretation is explored further in Theme 3b.

Other participants also described negative experiences of the CBT supervision and the discharge policies of their placements. Most participants held a negative perception of CBT

because of its perceived affiliation with services that use it as a short-term treatment that offered limited scope and flexibility when it came to offering clients additional sessions. For example, Danielle believed short-term CBT might have limited benefit for clients, especially those with complex needs. She provided an example in her placement within the charitable sector, where she was advised by her supervisor that her client should be discharged from the service because that individual had not been responsive to CBT and additional sessions were unlikely to benefit them. While Danielle acknowledged the client's progress had been modest, she believed it to be significant when taking into consideration this person's unique life circumstances and the challenges they faced. She said:

> *I found myself actually arguing for the sake of my clients that this cannot be done in 8 sessions, and at some point I got quite upset. I said, I don't care what you think. He was my client, I know best (D: 175-178).*

This quotation conveys Danielle's disagreement with her supervisor's reason for discharging the client. While it is not possible to interrogate this event from the supervisor's perspective, for Danielle discharge was not in the best interests of the client. This provides the context to Danielle's emphatic statement, 'He was my client, I know best' which signified a possible breakdown in understanding and communication in the supervisory relationship. In turn, this experience may have contributed towards her negative perception of CBT as an approach affiliated with such practices.

Theme 1c: No set approach to be followed

An important theme that emerged was the participants' belief that integration was a superior way of working with CBT. This belief was informative in how they evaluated their experience of working with CBT as stand-alone approach. Typically, the participants

did not distinguish which type of integration they used in the placements. This reflected my unfamiliarity, and possibly uncertainty on behalf of some of the participants, with different types of 'integration' which can include 'integration', 'assimilated integration' and 'eclectic' as distinct strategies to combine two or more theoretical models.

For example, Danielle described how she had valued supervision in a placement that encouraged greater theoretical flexibility in her work. She said:

> *One of my supervisors, who's a senior supervisor (…) approaches clinical practice in an integrated way. So I think it was quite easy for me to pull through (with) different aspects that would actually meet my client's needs. So I guess that's a reason why I'm (a) pro-activist of integration (D: 508 -512).*

The implication is that Danielle thought her supervisor had been a positive role model. The reference to 'seniority' suggests a level of respect and deference for this supervisor's contribution to her work in this placement. Her preference for following an integrative approach could in part be explained by this positive experience of supervision. The phrase 'it was quite easy for me to pull through' indicates that it gave her greater flexibility and possibly creativity in the therapeutic process, and stood in stark contrast to her negative experience of supervision in her CBT placement described previously in Theme1b.

Ellie said:

> *Yeah. And, what I see now where I work is that CBT is very much used in a kind of cherry picking-type way, so psychologists use the bits that they think will suit that client rather than to just a set protocol, one size fits everybody (E: 151-153).*

The description of how, in Ellie's perception, CBT components or interventions were being 'cherry-picked' by therapists to suit their clients' circumstances is indicative of what she saw as an eclectic approach in which the best interventions are chosen by a therapist to provide a tailored therapy that will meet the client's needs. It is also apparent that she regarded this as preferable to a 'one size fits everybody' policy associated with a CBT-only approach she had experienced in her previous placements. Most participants expressed their preference for this alignment possibly because they saw this approach as allowing for multi-theoretical insights that they believed had not been able to find expression in their CBT-placements. This theme is explored further in Theme 2a.

Christine described using an integrative approach that combined psychodynamic therapy and CBT for clients with personality disorders.

Christine said:

> *... I assimilated the CBT techniques in for what I mentioned like in terms of working in dependent personality disorders and various other personality disorders like narcissism and so on. (C: 459-466).*

Christine's reference to her use of psychodynamic therapy with CBT techniques in her work with clients with personality disorders indicated her support for her belief that psychodynamic therapy's understanding of relational dynamics improves upon a CBT-only approach. It was significant that her ability to work in this way was at the discretion of this placement but not her CBT-placement (as previously explored in Theme 1b).

Danielle explained that her recent placements also used an integration approach. She said:

... the sort of approach there is quite flexible. There's no sort of set approach to be following with the clients, (...) given the client complexity, it would be one of integration (D: 96-97).

From her comment that her current placement was 'quite flexible' in the range of therapeutic approaches it offered it may be inferred that this had allowed her to adopt an integrative or eclectic approach to therapy. Her preference for integration can be understood in the context of her previous experiences of using CBT as a stand-alone approach. Like other participants, Danielle appears to have regarded CBT as an effective therapy for common mental health problems but to have preferred to have the option of using a wider range of tools including integration to achieve a superior approach, especially when helping clients with more complex problems.

Finally, Amy described her course's training as encouraging an eclectic approach:

... it's bits and bobs of CBT techniques that you might throw in your toolkit along with a gazillion other things that we're exposed to (A: 710-711).

Here, Amy was critical of her course's training that appeared to encourage an 'eclectic' approach. As explored in Theme 1a, Amy felt it was important for trainees with less experience to have a solid grounding in CBT. An interpretation to be drawn here is that while Amy felt confident in her ability to integrate different theories with CBT into her practice, she likely placed value on learning CBT well before integrating it. This requires a level of understanding of CBT that she may have felt others on the course had not yet acquired. The use of the phrase 'bits and bobs of CBT' juxtaposed with 'a gazillion other things' could also be interpreted as expressing her own view that CBT's value lies in its

constituent parts, and not as a stand-alone evidence-based approach. This interpretation is further explored in Theme 2a.

5.2.2 Theme 2: CBT conflicts with counselling psychology's values

This research suggests that the influence of counselling psychology values of pluralism, a humanistic perspective, and the saliency of the therapeutic relationship was evident in the participants' experience of using CBT in their placements. These values are thought to be widely held by trainee and qualified counselling psychologists. Allegiance to these values seemed to lead the participants to criticise CBT as stand-alone therapy. In this regard, their allegiance to these values closely relates to their belief in integration as a preferred approach (explored in Theme 1). By focusing on the participants' belief in these professional values, Theme 2 helps to provide a better understanding of how these values relate to the participants' preference for integration and of their critical stance towards CBT's value in their future practice (explored in Theme 3).

Theme 2a: CBT sits alongside other theories

As a philosophical concept in counselling psychology, pluralism rejects a mono-theoretical position in favour of a critical evaluative stance on the relative merits of all therapeutic approaches. It could be argued that a preference for integration as a therapeutic approach reflects a particular expression and interpretation of these values, an interpretation that may not, of course, be generally shared by trainees and qualified counselling psychologists. The participants had all practised other approaches aside from CBT and believed them to have value. Their perception that CBT services, as they had experienced them in their CBT placements, did not value insights from alternative schools of thought appears to have been instrumental in their general critique of CBT as an approach. This often led to frustration

when participants felt they were prevented from discussing these alternative theories in supervision and from using them in clinical practice.

For example, Ellie said:

> *I've sounded very anti-CBT, and I'm not. ... but it's interesting doing this because I feel like I've kind of (said) IAPT services are awful and we talked at uni about ... the McDonaldisation of therapy now that it's kind of one size fits all (E: 509-512).*

Ellie's expression of concern that her portrayal of CBT had been overly negative followed a chronological exploration of her experiences of working with CBT in her placements that included an IAPT service and an acute in-patient ward within the private sector. From this it was apparent that her earlier experiences had given way to a greater appreciation of CBT, notably when it was integrated with PCT. Because she had not enjoyed her earlier experiences of using a CBT-only approach she wanted to clarify her position. However, she then continued to criticise CBT indicating that despite recognising its strengths, she believed a CBT-only approach was problematic. This appeared to reflect her belief that IAPT services were contributing to the standardisation or 'McDonaldisation' of therapy by not providing therapies other than CBT such as PCT.

While Fiona valued many aspects of CBT, she also believed it was improved by integrating it with PCT. Fiona said:

> *... I approach CBT as another tool, rather than kind of the central tool that I use. And I try for a more person-centred approach over a CBT approach (F: 383-385).*

Here, Fiona advocated using PCT as a theoretical 'approach', alongside CBT as a 'tool'. This appeared to reflect her belief in and an interpretation of pluralism, where different

therapies can provide a therapist with flexibility in how they address a given client's needs. An interpretation to be drawn is that this strategy appears to be closely related to the perceived weakness Fiona had encountered in her CBT placements (see Theme 1).

Amy's accounts implied a strong belief in the concept of pluralism. She said:

> *I have never been a therapist who identifies myself with a particular model…I don't have any problem at all with person-centred theory sitting alongside cognitive behaviour theory sitting alongside other theories because that's what they are. They're just theories. (A: 861-866)*

This comment appeared to reject the very notion of allegiance to a theory by stating that she had no problem with theories 'sitting alongside' each other. While this supported her confidence in taking a pluralistic perspective, it was notable for the absence of a critical evaluative stance towards different theories. It could be argued that evidence-base practice indicates that some theories are more effective than others when treating certain mental health problems but, despite this, other participants appeared to share this interpretation of pluralism in which all therapies are considered equally valid.

Theme 2b: First the relationship, then CBT

A multi-theoretical conceptualisation of the therapeutic relationship can include PCT, psychodynamic, and CBT perspectives amongst others. PCT conceptualisation is associated with the humanistic tradition of counselling psychology linked to participants' empathy, and openness to their clients' unique lived experiences. A psychodynamic perspective is inherent to exploration of relationship dynamics. CBT's ability to help establish a therapeutic relationship with clients, also known as a 'working alliance', was not acknowledged by the participants except for Becky.

Becky said:

> *But I find that using CBT…just…it helps me build a good relationship with the client I find. I find using CBT quite enjoyable to use. (B: 561-562)*

Having never worked with CBT before, Becky likely found that working collaboratively with clients through shared goals helped to build rapport. Other participants did not explicitly mention this but it could be inferred from their positive experience of collaborating with clients in their implementation of CBT interventions (see Theme 3a). However, the general perception amongst the other participants was that the CBT understanding and approach to the therapeutic relationship was weak compared to those used by other therapeutic approaches, which helps to explain why they did not explicitly make reference to valuing the working alliance in their CBT placements.

For example, Ellie said:

> *... maybe it's the way that CBT appears to be rolling out in lots of NHS services ...for me, it feels like it's being taught in a way that would work in a call centre where you just follow a script whereas I think it's about building a relationship and then using some of the CBT, you know. (E: 369-373).*

Ellie's use of metaphors conveyed her negative opinions about how the NHS delivers CBT services, implying that these services do not encourage an emotional connection with their service users. This opinion was likely to be informed by Ellie's belief in PCT that emphasised the importance of using empathy, unconditional positive regard and congruence to build a therapeutic relationship in therapy. Given her own experiences she

seemed to be under the impression that other NHS services and CBT therapists do not express these positive attributes in their work (see Theme 3b). She then said:

> *... we're kind of trained and we have all this personal therapy we really think about ourself (...) within the therapeutic relationship and it would be awful to think if that all just got boxed down and forgotten about and that we all became robots but that's being very dramatic, yeah (Laughter) (E: 460-464).*

In this quotation, Ellie highlighted the role of personal therapy which is a mandatory component of counselling psychology training. She implied that it helps trainees to develop insight into relationship dynamics and expressed concern that such skills were being 'boxed down' and 'forgotten about'. To make her point, however, she appeared to recognise that for dramatic effect she had over-generalised and exaggerated the extent of the problem. Her statement implied that from her perspective the therapeutic relationship was a focal point of counselling psychology training that was not shared by other therapists currently working in CBT services.

Fiona also stated that the therapeutic relationship was important in her work and that CBT could be improved by integrating PCT' theoretical s understanding of it. She said:

> *But (I am) probably am a good bit looser than a real CBT therapist, but I think…yeah, my nature is just to be a little bit more free-flowing about things, and maybe I feel that that is person-centred and that that isn't CBT, you know…In some way that's my way anyway of being okay with being a counselling psychologist and bringing back kind of more humanistic, open, empathetic thing to it, while also doing CBT being structured and making sure the work gets done and that kind of thing (F: 267-272).*

This indicates that Fiona's belief in PCT and its humanistic values (see Theme 2c) influenced how she used CBT. She felt that without these values CBT did not allow empathy and respect to be expressed fully. From her perspective, CBT's use of rigid agenda setting did not provide enough flexibility to attend to the therapeutic relationship. 'Bit looser than a real CBT therapist' reflected a perception that other therapists do not integrate humanistic values as they are only concerned with delivering treatment plans. This helps to explain why Fiona and Ellie believed that their practice of CBT differentiated them from a 'real CBT therapist' who does 'pure CBT'. They had experienced a stand-alone approach to CBT in their placements and had been critical of it for its perceived limitations (explored in Theme 1).

Christine said:

> *... trainee status can really be quite frustrating in lots of ways because you can see a lot more of what's going on in terms (...) transference, the attachment style, how people might avoid therapy (C: 72 -75).*

Christine had already worked with CBT at an IAPT service before starting her counselling psychology training. She continued to use CBT but her approach developed to include psychodynamic therapy. Here, she described how psychodynamic insights of the therapeutic relationship had not been valued by her CBT placements with a forensic unit. Given her new knowledge of psychodynamic understanding of relationship dynamics, she appears to have felt her 'trainee status' acted as an inhibition to using this approach in her formulation. From this it can be inferred that she believed CBT was limited by not including such insights in its formulation of a client's problems, a belief related to her negative experience of using CBT as a stand-alone approach (explored in Theme 1b).

Theme 2c: CBT oversimplifies problems

In line with the humanistic ethos of counselling psychology the participants wanted to recognise their clients as unique beings and to tailor therapy to their specific needs. However, this was not always possible when they perceived that CBT oversimplified their clients' problems and the treatments it informed. In part this belief can be explained by the participants' CBT placements in IAPT services, community mental health charities, and student counselling services where they treated clients with common mental health problems. By contrast other placements, including specialist settings such as an acute in-patient ward, a hospice, and an eating disorder service where they saw clients with more severe and complex problems, enabled them to practise integration. While guidance received in their CBT placements may have contributed to their perception of oversimplification, the participants appear to have attributed it to CBT as an approach.

This quote below illustrates a common association made by the participants about CBT and the type of problems it was best suited to treat. Amy said:

> *they're like self healers () They'll go off and read a book about it. They'll come back and say well, I've actually just been doing a whole bunch of self-help on myself. () And you're like well, that's great because you've done my job (A: 580-586). For fairly straightforward presentations, I think (CBT) is a fantastic and (a) well organised use of a therapist and client's time (A: 642-643).*

Here Amy was describing her placement in a university counselling service. On the one hand the term 'self-healers' has positive connotations, referring to her clients' ability to engage with CBT and its self-help material. On the other hand, the self-motivation and self-reliance of these 'self-healers' appears not to have been a challenging or rewarding experience for Amy as a therapist. Her statement that CBT is a 'well organised use of a

therapist's and a client's time', seemed to reflect an appreciation of how CBT did not require her to invest too much time with these clients for her sake as well as theirs. Amy's description of CBT as a 'fantastic' treatment for 'fairly straightforward presentations' may be mainly significant for the implication that CBT is not suitable for clients with more complex problems.

During the interview Ellie expressed some concern over how well CBT was being practised in her placements which including an IAPT service. She found that her work in these placements relied on standardised treatments. Ellie said:

> *I don't think (CBT) can be used in a uniform way, that's just my personal opinion. I think it needs to be kind of tailored to the client and where they're at (E: 142-144)*

It seems likely that CBT practitioners and services would agree with Ellie that CBT needs to be 'tailored to a client and where they're at'. However, the quote highlights how Ellie believed that CBT was not achieving this through standardised or 'uniform' approaches. The qualifier, 'that's just my personal opinion', likely refers to her formative experience with a CBT supervisor who instructed her only to use CBT, not PCT (explored in Theme 1c). An interpretation to be drawn here is that Ellie was implying that, by oversimplifying clients' problems and concerns, CBT did not express humanistic values.

Fiona also believed that an over-reliance on CBT could be problematic. She said:

> *... it's used for too much, like it's kind of relied on too much. It's kind of like fall back for everything, so I guess I struggle with that. Sometimes I do feel like we kind of put people into boxes. You're sometimes trying to write things down and sometimes it over-simplifies things a little bit, while it can be helpful to some people to kind of write things down and structure things, but for other people I think it can*

be a bit like it over-simplifies their problem, so it doesn't feel quite right (F: 302-306).

Fiona's belief that CBT was the 'fall back for everything' implied that it was over-relied upon as a treatment. Putting 'people into boxes' appeared to refer to the use of diagnostic labels such as depression to determine their treatment plan. This opinion likely reflected her belief in the value of the PCT approach which arguably places less emphasis on diagnostic labels and more focus on the therapeutic relationship as the key mechanism by which clients improve. This interpretation is consistent with Danielle's opinion that CBT can over-simplify the extent of clients' problems when the scope of their treatment plan is too narrow (related to Theme 2c). However, the use of 'kind of', 'I guess', 'kind of' suggests Fiona had some doubts over whether such claims were categorically true for all cases. Fiona later said:

it comes up a lot (...) CBT just isn't enough. (...) CBT formulations can be fine, but with really severe presentations I don't think it...goes anywhere near enough to explaining them (F:402-404).

Here, Fiona explained how CBT was used as part of an integration strategy in a placement in an in-patient ward, where she found CBT formulations were perceived to be inappropriate for clients with 'severe presentations' as they lacked explanatory power and provided ineffective treatments. While 'complex' and 'severe' can be understood to mean different things, Fiona appeared to present 'severe' as shorthand to refer to both. This experience seems to have reinforced her belief about CBT's use and its value, explored in the previous statement.

5.2.3 Theme 3: Deconstructing & assimilating CBT

For many participants, their first experience of CBT was in a placement that required them to use it as a stand-alone therapy. This appeared to be a formative experience that shaped their subsequent opinions about CBT as a therapy. As the participants gained more experience and confidence, they began to see the value of CBT's interventions and techniques but criticised its many apparent weaknesses. They appeared to place greater value on CBT's constituent parts than on the approach itself. The word 'deconstruct' seemed apt to describe how the participants reduced CBT to its constituent parts in order to reinterpret its meaning. Their placement experiences and interest in integration appeared influential in determining how they might want to draw on CBT's resources in their future work.

Theme 3a: CBT provides structure and permission to challenge

All of the participants valued the positive results they had achieved through CBT interventions. The participants recognised that CBT had provided them with interventions and techniques that helped their clients. A few of the participants even described CBT as an empowering approach.

Fiona said:

> *I actually like being able to… having the permission I suppose to challenge things and …more… power actually, I guess, and more freedom to the therapists than person-centred would, which can be a bad thing (F: 275-278). There is something about being able to put structure on things for someone who feels that they've no structure (F: 287-290).*

In describing how CBT gave her permission to challenge clients Fiona is likely reflecting her prior experience of using PCT as an approach that did not confront clients directly. In

this sense, ‘more freedom’ could be interpreted as a positive experience from taking a more proactive role in the therapeutic process. However, Fiona noted that such proactivity could also be considered as a weakness of CBT when it did not afford her clients the same opportunity to express their thoughts and feelings as in PCT. This theme is explored further in Theme 2b.

Danielle said:

> *I think it's a sort of immediate improvement people notice and I really like it when … you engage in some behavioural experiment and the clients are actually confident that it's not going to work out…(and) they come in the next session they're actually succeeding and they're so happy with themselves. And that is something I really enjoy with CBT (D: 365-370).*

This picked up on the pleasure she felt at seeing the positive impact of CBT interventions such as behavioural experiments on her clients. Like Fiona, Danielle was initially trained in PCT and seemed to be alluding to the freedom afforded by CBT to be more proactive in her client’s treatment. In this example her satisfaction is evident in the ability she felt to challenge her clients to undertake activities deemed to be in their best interests even if they were initially reluctant to do so. Like Fiona, Danielle believed this could have unwanted consequences (see Theme 3b).

Ellie found another CBT intervention was useful. She said:

> *(I really value) the psychoeducation of just getting down to basics and explaining the panic model and the physiology of the kind of fight-flight response. I think there*

is great power in writing things down, kind of seeing it in front and kind of the diagrams and kind of the visual side of it (E: 135-138)

Having used PCT in her first placement as a CBT novice it was probably a revelation to discover the power of using psychoeducation as an intervention. Psychoeducation is commonly used in CBT to explain mental health problems through the interconnections between particular thoughts, feelings, and behaviours. In this context, the 'power' of 'writing things down' could be interpreted as the ability to help her clients gain an understanding of their mental health problems, perhaps for the first time.

Theme 3b: CBT is focused is both its strength and its weakness

While the participants had many positive experiences of using CBT, they also had negative experiences that appeared to be more influential in shaping their opinions about CBT. Notably, many felt their ability to use multi-theoretical concepts was unnecessarily restricted by their CBT placements' insistence on using only CBT-theory. This had the effect of shaping a belief that CBT was overused by services in an excessively rigid manner. This theme is closely related to themes 1 and 2 that explored the participants' preference for integration and their interpretation of professional values. However, it also captures other aspects of CBT that have helped to inform their general critique and stance towards CBT as a therapeutic approach.

Danielle, for example, had worked with clients with physical health problems, learning disabilities, and housing problems in one of her CBT placements. She believed that CBT had helped these clients but only to a limited extent. She felt that her placement's insistence on standard CBT treatments for common mental health problems did not

adequately consider these clients' underlying biological, social, and financial problems (previously described in Theme 1b). She said:

> *So you can understand at that point that CBT is not really the magic solution for these people and it does nothing to them (D: 325-326).*

'CBT is not really the magic solution', was a strong declaratory statement that appeared to express Danielle's frustration about her placement's approach to CBT. It is unclear what motives her placement had for using standardised treatments for such clients or whether onward referrals had been adequately considered. From Danielle's perspective, however, she felt the placement had not appreciated the client's unique circumstances or challenges in the allocation of sessions. Danielle's use of the word 'to' in the phrase, 'it does nothing to them' conveys the message that an ineffective short-term CBT treatment was being imposed upon such clients. In turn, this helps to explain why she felt that CBT was 'not really the magic solution' for such clients in this placement, and by association the CBT approach itself.

Amy criticised CBT as an approach that could be too directive or structured. She said:

> *It's focused. And I suppose that's both its strength and its disadvantage, because CBT can be extremely focused but it doesn't necessarily always create space for the nuances or for other things that the client may need to bring in, which are actually quite important to the client, because the CBT is like nope, we're here to talk about your depression… (A: 638-642).*

Here Amy highlights an apparent paradox alluded to by other participants. On the one hand, it seems CBT can provide clients with 'focus' through a structured treatment but on the other, the same structure could limit their ability to explore freely concerns that could

prove to be pertinent to their treatment. It could be argued that there is a need to strike the right balance but they are shown here as conflicting principles, CBT being depicted as an approach that is uninterested in finding this balance. It is possible that this opinion reflects Amy's belief in prioritising the therapeutic relationship in her CBT work (explored in Theme 2b) and suggests she holds an underlying assumption that others do not consider this to be as important in their CBT approach.

Ellie also criticised CBT as an approach from a psychodynamic perspective. CBT's concepts of core beliefs and schemas do consider unconscious processes and conflicts but they are arguably more central to psychodynamic understanding of psychological distress. She said:

> *Yeah, I think unconscious stuff that's maybe coming up, there's no place for it in pure CBT, that's just my thought. It's dismissive. But then, for some clients, I think that works well to have the agenda. It makes them feel contained and makes them feel safe. They don't want it going off into other murky waters (E: 194-198).*

Ellie's reference to the 'unconscious stuff' having no place in pure CBT, may have referred to process issues that arose in her work which are often associated with the psychodynamic concepts of transference and countertransference. Her supervisor had not encouraged a multi-theoretical perspective in her CBT work during the IAPT placement (explored in Theme 1b) but she acknowledged that some clients prefer CBT and an agenda, as they 'feel contained' and 'safe'. For such clients, the unconscious feels akin to 'going off into other murky waters'. It is unclear from these statements whether Ellie considered that CBT is a safe therapy and psychodynamic therapy is a less safe option but it suggests that Ellie felt CBT was weakened by not including such insights.

Theme 3c: Assimilating CBT

As final year trainees the participants were considering how they might work when qualified. Most said they would use CBT as a stand-alone approach but in limited situations. However, they hoped to use CBT as part of an integration strategy by combining it with PCT or PDT, assimilative integration being the preferred way to achieve this. On the one hand, their interest in integration reflected their critical evaluation of their first-hand experiences of working with CBT. On the other hand, their plans to use CBT techniques selectively, rather than the full approach, implied their experiences had led them to disengage from CBT as an independent theory and practice.

Becky believed her interests in PDT and CBT could be combined and expressed through integration. She said:

> *... in the third year (...) we're taught about (...) assimilating the two (B: 549 -550) I find that I'm always bringing in CBT techniques regardless of the approach I take (B: 555).*

Becky had previously described her interest in working with both PDT and CBT. Integration appeared to be a way to address the relative strengths and weaknesses of these two approaches. In regard to CBT this included a belief that PDT was superior at addressing issues relating to a client's past, their relationships with themselves or with others. In the quote, Becky mentioned that her course 'taught about' assimilating CBT and PDT with final year trainees. She seemed uncertain about the details, but the expression 'I'm always bringing in CBT techniques' implied PDT would be the primary approach.

Like Becky, Christine also considered integration PDT and CBT on the course. Christine said:

I know that I've looked at kind of how I'd like to practice in the future (in an essay) (C: 461) CBT has given (me) a reasonable foundation in terms of techniques and where it fits I think is ultimately the techniques of the therapy (C: 459-461)

In the above quote Christine appeared to be somewhat clearer about how she might achieve integration. During the interview, she expressed an interest in object relations as a PDT approach and like Becky perceived CBT to be limited in its ability to address relationship dynamics. However, in spite of this interest the phrase 'CBT has given (me) a reasonable foundation' indicated some hesitation and apprehension about this strategy. An interpretation to be drawn here is that, while Amy gained CBT experience before and during her course; there was perhaps recognition that more CBT 'techniques' could be considered in such an integration strategy.

Ellie also expressed an interest in integration. She said:

I think (a relational approach) is incredibly important. Whether relational on its own, not sure; CBT on its own, not sure; for me, it's kind of blending it (E: 350-358).

I think it's kind of integrating everything about the person of how they relate to you, the therapeutic relationship, how they are in their family environment and social environment, their childhood and then kind of sometimes talking can open that up and then sometimes the practical skills of CBT can help (E: 360-364)

As described in previous sections, Ellie believed CBT could oversimplify a client's problems and concerns by not tailoring therapy to their specific needs and life circumstances. These quotes illustrate this critical evaluation of CBT and Ellie's desire to improve CBT by 'blending it' with PCT to create a more relational approach. The

repetition of ‘not sure’ indicated some uncertainty over how she might achieve this. However, the description of using ‘practical skills of CBT’ ‘sometimes’ implied that Ellie might be considering an assimilative integration strategy, as suggested by other participants.

6. DISCUSSION

6.1 Discussion of the themes

This IPA study aimed to provide an original contribution to the existing literature through an open enquiry into how trainees experience working with CBT in their clinical placements. The literature is primarily the product of research and commentary by trainees and qualified counselling psychologists who express concerns about the approach to CBT by NHS and IAPT services. The transferability of these findings to the contemporary experiences of trainees who work with CBT in other sectors as part of their professional development was uncertain. To establish the contribution made by this study the superordinate themes presented in the findings chapter will be discussed in relation to existing theory and research. The limitations of the study will also be discussed before making concluding comments and recommendations for future research.

6.1.1 Theme 1: Pure CBT vs. integration

Clinical placements are understood to be a cornerstone of trainee counselling psychologists' professional development during which they learn to put theory into practice (Kahr, 1999). Internet research found that CBT is taught as a primary or secondary model on more counselling psychology courses than any other model. Consequently, it seems likely that most trainees will be practising CBT as part of their professional training in counselling psychology.

In this study, many participants recognised the importance of CBT placements as a means to supplement the training they had received from their courses with additional self-directed learning. On the other hand it is apparent that some participants, especially those who started their course as CBT-novices, held unrealistic expectations about the level of

expertise they would have developed as final year trainees. This accords with previous studies which suggested that trainee counselling psychologists may have an unrealistic expectation that they will be 'experts' by the end of the training (Efstathiou, 2017; Szymanska, 2002). Szymanska (2002) wrote:

> "Training courses are not designed to teach trainees everything they need to know about counselling psychology. Rather, training opens the door to further accumulation of knowledge, learning of new theories and techniques, increase in confidence and ability" (p.20)

Excessively high expectations may have contributed to the disappointment that some participants expressed over the theoretical and practical skills training they had received and the level of CBT competency they had developed as final year trainees. This may have reflected an ambition on their part to work in the public sector after qualifying, as they believed such skills were often required there. However, CBT was taught as a secondary not a primary model on their courses and they may have found that they were only expected to demonstrate a 'working knowledge' rather than expert knowledge by the end of their training (BPS, 2014). Participants appear not to have anticipated that greater expertise in CBT would require additional training during and after their course (Golding & Gray, 2006). To illustrate this point, it is likely that newly qualified counselling psychologists wishing to work as high-intensity therapists in IAPT services or to apply for accreditation with BABCP as 'CBT therapists' will require specialist CBT training (Curran et al., 2010).

Studies by Efstathiou (2017) and Szymanska (2002) have provided a useful overview of different areas in which unrealistic expectations among trainees about their personal therapy, personal growth, and the financial and emotional demands of their courses can impact upon their experience of the course. A better approach towards managing

expectations in order to improve the participants' sense of confidence to practise CBT and reduce their sense of disappointment with their course could be a valuable topic for further research.

Participants used CBT as a stand-alone approach in placements within different organisations in the charitable and public sectors. Although this provided a considerable diversity of experience, they all expressed similar concerns about delivering CBT as a short-term treatment when it did not align with counselling psychology's values (explored in Theme 3). In turn, these experiences and their perception that similar misalignment existed in other CBT services appeared to shape a negative evaluation of CBT (explored in Theme 4). Consequently, they appear to have had a positive experience of using CBT as part of an integration strategy in different placements, which seems to have reinforced their critical stance towards CBT's use as a stand-alone approach.

Levi's (2010) IPA study of eight qualified counselling psychologists' experience of the therapeutic relationship in CBT found that the free or mandatory use of CBT could affect how it, and the therapeutic relationship within that approach is perceived and experienced. This finding is based on the accounts of six participants who reported certain pressure to use CBT rather than other approaches in NHS settings. The study found that participants reported positive experiences of using CBT in placements that allowed theoretical flexibility in their work, and negative experiences of working with CBT in placements that required it to be used as a stand-alone approach.

As proponents of integration, the participants believed it was superior to using CBT as a stand-alone therapy. This is significant when attempting to understand their perceptions

and their evaluation of working in placements, especially with supervisors whom they perceived not to support their point of view. A demand that they should restrict themselves to a ‘CBT-only' approach in these placements often led to feelings of frustration and a sense of dissatisfaction with their work. These concerns reflected views previously reported by trainees and qualified counselling psychologists in their pursuit of integrative approaches in CBT services within the NHS and IAPT services (Hapney, 2016: Wade et al., 2011).

Dobson's (2012) discursive analysis thesis of how six women counselling psychology trainees experienced the supervisory relationship in counselling psychology concludes that ‘conflicting paradigms' can occur when supervisors and their charges do not share the same perspectives. This was surmised after a trainee suggested the level of qualification required to be a counselling psychologist was sufficient to justify resistance to the authority of supervisors as experts. ‘Conflicting paradigms' is an apt description of the differing perspectives participants and their supervisors took with regard to integration. It led the participants training in PCT and PDT to question both their supervisors’ and their placements’ use of CBT as a stand-alone approach. It was a discourse in which the trainee-participants seemed to assume the position of ‘expert' whose knowledge was superior to their CBT supervisors. This was in contrast to the ‘expert' position (sometimes used to describe their supervisors) in other placements that encouraged the integration of different models.

6.1.2 Theme 2: CBT conflicts with counselling psychology’s values

The research found that the participants' belief in their professional values, expressed strongly in the interviews, exerted a strong influence on how they experienced their CBT

placements. This supports the premise in the literature on counselling psychology's professional identity that these values may be as important to trainees as they are to qualified counselling psychologists (Gallagher, 2014; Hore, 2014; Mantica, 2011; Stapley, 2014; Verling, 2014). This belief was attributed to pluralism, the saliency of the therapeutic relationship, and the humanistic ethos of the profession.

The key to understanding why professional values were important to the participants' experience of their CBT placements was the concept of pluralism, which stipulates as a philosophical concept, "that any substantial question admits of a variety of plausible but mutually conflicting responses" (Rescher, 1993, p. 79). From a counselling psychology perspective, this is an acknowledgement that different therapeutic approaches may all have value when addressing a client's problems (Cooper, 2008). It was a philosophy that had informed the participants' pluralistic training in other models aside from CBT.

Arguably the participants' belief that these models could add value to clients' CBT treatment resulted directly in conflicts of perspective between them and their supervisors or placements who expected them to work with CBT as a stand-alone approach. The consequent lack of freedom to use alternative perspectives has been suggested as a reason why some trainees might not enjoy working with CBT in certain work settings (Boucher, 2010; Rizq 2012). This was found to be the case with participants in this study who believed their placements restricted them unnecessarily to using CBT exclusively to understand their clients' problems. Without having these multi-theoretical insights addressed in supervision, participants perceived their work to have a narrow focus and, consequently, to be prone to the over-simplification of their clients' problems.

The existing literature has focused on the challenges and rewards of adopting a pluralistic perspective during training (Cooper, 2008; Rizq, 2006), but in this study the focus has been on the participants' frustrations arising from the restrictions they felt was placed on their efforts to draw upon two or more models in their work. In their CBT placements, this approach aligns with 'assimilative integration' that has been used by other trainees and qualified counselling psychologists in CBT service. It can be understood to represent a particular interpretation of how pluralism can be implemented in practice. It is probable that the supervisors had a different understanding of 'pluralism', in which CBT as a stand-alone approach was deemed to be the most appropriate treatment for their clients. The participants' pluralistic perspective was evident in their belief that PCT or PDT could contribute to CBT's conceptualisation of the therapeutic relationship.

The participants' accounts of supervision in CBT placements implied that psychoanalytic concepts of 'transference' and 'countertransference' (Dryden, 2012; Jacob, 2004; Leah, 2008) and humanistic attributes of warmth, accurate empathy, and genuineness (Beck, 1979; Dryden & Branch, 2012) were not encouraged. In this regard, the importance of the therapeutic relationship or 'working alliance', described by leading authorities in CBT (Bodin, 1979; Ekberg & LeCouteur, 2014; Kuyken, Padesky, & Dudley, 2009) appears not to have been part of this supervision. Instead, the participants suggested that supervision focused on their use of CBT formulations, techniques and interventions. This implied that their supervisors did not consider the therapeutic relationship to be a principal mechanism of therapeutic change. However, the study does not provide us with a detailed insight into how supervisors addressed the working alliance or their views on its role in CBT.

A focus on the therapeutic relationship as a means to effect positive changes has been associated with a counselling psychology approach to therapy. Many believe this distinguishes the profession from other applied psychologists. CBT's conceptualisation of the therapeutic relationship has often been criticised by counselling psychologists for its lack of depth and insight (Boucher, 2010; Holmes, 2010; Mearns & Cooper, 2005), a criticism that was shared by participants in this study who believed a PCT or PDT approach to the understanding of the therapeutic relationship was superior. On the significance of counselling psychology values to its members, Cooper (2009) said:

> Counselling psychology is not only grounded in a set of values but that it is, in its essence, the application of those values (…) In other words, counselling psychology is 'ethics-in-action' (p.4)

It was evident that the participants, as trainee counselling psychologists, shared this sentiment in the way they wanted to express the saliency of the therapeutic relationship in their placements. They appeared to be disillusioned by their experience of working with supervisors and placements they felt had overlooked this aspect of therapy. Subsequently, they were often critical of CBT that they perceived focused on technical aspects such as setting agendas and implementing interventions, not the therapeutic relationship. While they recognised the benefits of providing clients with a structured therapy, they were concerned that over-reliance on structure and the delivery of interventions could reduce their ability to utilise the therapeutic relationship as a vehicle by which to explore their clients' problems in greater depth, and could lead to a missed opportunity to promote further positive outcomes for their clients.

These themes can be found in Mantica's (2011) IPA thesis on the impact of working with CBT on the professional identity of qualified Counselling Psychologists. The study found

that seven of the participants who worked in NHS settings described CBT as a logical, pragmatic, directive, brief and solution-focused approach that could constrain and place limits on being with the client and was less authentic than other approaches. The similarity of these accounts with those provided by the participants in this study suggests this may be a commonly held perception, the common theme being the challenge associated with prioritising the therapeutic relationship while at the same time meeting expectations that they will deliver CBT interventions with a limited number of sessions. The concern is that this is a work environment in which they often feel they cannot spend as much time as they would ideally like to explore relationship dynamics.

This study found that the participants' belief in counselling psychology values often led to feelings of frustration with certain operating policies and that guidance from supervisors was perceived to restrict their freedom of expression. Even though participants acquiesced in these policies and guidance, they did so because they were aware of their limited ability as trainees to influence decisions within the placements. However, these experiences appeared to be formative in causing them to question how well their placements were serving the best interests of all their service users.

6.1.3 Theme 3: Deconstructing & assimilating CBT

All the participants recognised the practical techniques and interventions CBT had provided them with, as well as the effectiveness of the approach - especially for clients with common mental health problems. Those participants who had been taught PCT on their courses as a non-directive therapy - an approach that assists rather than instructs clients to understand their experiences (Brammer, Shostrom & Abrego, 1989) - found that CBT, as a more directive therapy, gave them greater autonomy to challenge their clients.

This approach enabled them, for example, to use Socratic questioning to uncover their clients' underlying thoughts or beliefs. It also helped them to overcome clients' resistance to completing behavioural experiments as homework exercises. Compared to PCT, they found that the CBT techniques and interventions provided them with a more direct route to promote positive change.

While recognising these positive attributes, participants also associated CBT with what they perceived to be unhelpful or counterproductive operating procedures and policies experienced throughout their placements. Consequently, even though all the participants said they would use CBT as a stand-alone approach in certain situations, they planned to use it as part of an integrative approach, and were not happy to entertain the prospect of only working with CBT. In their view, integration aligned with their professional values because they thought it offered them greater autonomy and flexibility in their work, enabling them to express pluralistic and humanistic values, whereas CBT did not. The similarities between their accounts suggest the practices that had caused them concern were commonplace and that they perceived that economic factors and the pursuit of operational efficiency to be the main priorities in organisations involved with CBT placements in both the charitable and public sectors.

Boucher (2010) and Mantica (2011) suggest that a counselling psychologist's views on CBT would likely depend on their theoretical orientation and the work settings. This study also supports this premise, since the participants' interest in integration as an emerging therapeutic orientation proved problematic when placements and supervisors did not support them in this direction. The participants also felt restricted by a CBT-only approach, which they saw as a short-term treatment that did not always uphold their humanistic ethos

of counselling psychology and its emphasis on the saliency of the therapeutic relationship (Boucher, 2010; Robins, 2014; Ramsey-Wade, 2014). Significantly, the participants in this study expressed these concerns not only in placements in NHS or in IAPT settings (Cooper, 2009; Milton, 2010; Rizq, 2012; Strawbridge and Woolfe, 2010) but also within the charitable sector.

The participants' negative perception of CBT as stand-alone approach appears to have been reinforced without exception by their placement experiences. Nevertheless, this still leaves a question as to how far the participants' experiences of CBT - common as they might have been - fairly represent the position across the board. From the participants' accounts it appeared that negative experiences of working with CBT exerted a strong influence over how they viewed CBT as an approach. However, certain CBT practices they reported, especially those regarding the perceived unimportance supervisors placed on the therapeutic relationship, do not appear to reflect what leading CBT authorities have described as being best practice in this area. Consequently, the participants gave the impression of attributing their concerns about supervision or a placement's operating policies and procedures more generally to CBT as an approach. It seems highly unlikely that all placements adopt such a uniform stance in their delivery of CBT and unlikely that all CBT supervisors will provide the same guidance to trainees on how they should work with the therapeutic relationship. Arguably other trainees may have had a different experience of working with CBT in their placements either because their emerging therapeutic orientation aligned with CBT or they perceived that an emphasis was placed upon the importance of the therapeutic relationship in supervision.

6.2 Possible limitations

Criteria set by Yardley (2000) by which to evaluate qualitative research provide a useful framework from which to assess the quality of this study and to recognise its limitations. They include: ‘sensitivity to context', which explores how well the research considered its sociological and historical context; ‘commitment and rigour' which explores the methodological steps it used; ‘transparency and coherence', which explores how well the research addressed the research question; and ‘impact and importance', which explores how well it addresses the research question and contributes to the field of knowledge in this area.

6.2.1 Sensitivity to Context

The critical literature review explored the sociological, economic, historical and political forces that have made CBT a therapy of choice for mental health services and caused it to become an essential feature of all counselling psychology programs in the UK.

The participants represented courses in which CBT was taught as a secondary model. It is possible that different insights could have been obtained from a sample of trainees from similar courses who were taught CBT as a primary model but further research is needed to determine how and why. The level of training that participants had received in CBT prior to starting their courses had not been adequately considered in terms of its potential impact on their subsequent experience of working with CBT in their placements. Two participants had gained a ‘working knowledge’ of CBT, and the other four participants were ‘CBT novices’ when they started their course. This had a direct influence on their experience of their CBT placements as the route by which they developed CBT competency. The accounts of the ‘CBT novices’, nevertheless, provided adequate data by which to explore

Theme 1: Building confidence and competence. It was notably that the amount of prior training had no discernable impact on other themes presented.

The research focused on second wave CBT as it was perceived to be the mainstream approach likely to be used by trainees. It was noted that few participants reported having worked with other forms of CBT, commonly referred to as third wave approaches. It is important to recognise that CBT is often used as an umbrella term that encompasses all of these approaches (see McMain et al., 2015), and has proven itself to be highly adaptable. By focusing on second wave CBT, the research may not reflect trainees' work with the third wave approaches such as ACT or MBCT of which they may have had different experiences.

Gender might be an important consideration in how trainees perceive and experience their CBT work (Mantica, 2011). While the research did not find any evidence to support this claim in the analysis, it is possible that the participants - all female - might not have felt comfortable in disclosing such thoughts to a male researcher. Cultural influences were not researched or uncovered in the analysis. In future, a more selective sampling strategy would be needed.

6.2.2 Commitment and Rigour

The concept of commitment encompasses a prolonged engagement with the topic, development of competence in the methodology used, and immersion in the relevant theoretical or empirical data (Yardley, 2000). The researcher has been engaged with this research topic for the duration of his professional training in counselling psychology. Newly published literature has been reviewed and incorporated when appropriate. To

develop competency in IPA, the researcher drew on resources that included the Yahoo forum for IPA analysis, guidance from Smith et al., (2009) and academic supervision.

Regarding ‘rigour', Flowers, Smith, Sheeran, & Beail (1998, p. 412) describe this in terms of the analyst's attempt "to acknowledge and suspend any existing knowledge of the field and personal experiences within it". The researcher's status as a fellow counselling psychology trainee was both a strength and a weakness in this respect. It helped to facilitate an empathic relationship with the participants due to this common ground, but the familiarity with the topic led the participants and the interviewer sometimes to presume what the other might be thinking. On a few occasions, the opportunity to use follow-up questions to ascertain a participant's understanding was lost. Nevertheless, the overall quality and depth of the material presented was deemed sufficient for analysis.

While the analysis drew upon the researcher's knowledge of the phenomenon, or the ‘interpretative resources' (Smith et al., 1999), the themes that arose from the analysis and those presented in the findings were closely tied to the participants' description of their experiences. By rigorously following the methodological steps, as outlined by Smith et al., (2009), the perspectives of the researcher are made evident in the interpretation and discussion. This process enables readers to interpret the participants' accounts from both their perspectives and the researcher's contribution.

6.2.3 Transparency and Coherence

Transparency refers to the presentation of the analysis by detailing aspects of the data collection process, and coherence describes how well the methodology fits the research question (Yardley, 2000). For purposes of transparency, granular details of the

methodological process used in the study are available for review (see Appendices A, B, C & D). The study set out to investigate how trainee counselling psychologists experience working with CBT in their placements. It was considered important to provide an open investigation that did not presume what might be relevant to the participants.

The semi-structured interview format was successful in helping the participants to express their thoughts and feelings freely, but the questions posed (see Appendix A) informed the discussion. The questions had attempted to cover different aspects of the participants' experiences, but a significant interplay was found between these questions and the IPA themes reported in the study. It was observed that Questions 4 & 5, which related to positive and negative experiences of working with CBT, were closely associated with Theme 1. Questions 3, 6, 7 & 8, which related to the influence of academic and clinical supervision and professional identity, could be linked to Theme 2, while Questions 9 & 10, which related to the evaluation of CBT and plans to work with CBT after qualifying, can be attributed to Theme 3. This interplay between the questions and the IPA themes suggests that different questions might have uncovered variations on the themes. Future studies might benefit from exploring different questions or using an open-ended interview format to explore different aspects of the research phenomenon that may not have been reported in this study.

Homogeneity is needed to detect greater psychological variability within a sample (Smith et al., 2009). This was addressed by recruiting final year trainees with experience of working with CBT as a second wave approach in at least two placements. The recruitment strategy relied on trainees' self-selection and no financial incentive was given to participate. It was noted that the trainees who engaged in the study were enthusiastic. It seems likely

that those who participated were more motivated to express opinions on topics such as their training or their negative placement experiences, whereas those who declined may have felt they had little to say on the subject. As a result, self-selection may have biased the findings towards reporting more unfavourable views of CBT.

By attracting participants with these shared characteristics the homogeneity of the sample was further increased. All six participants were taught CBT as a secondary model and expressed an interest in integration as their emerging therapeutic orientation. Had trainees been recruited who had been taught CBT as a primary model with an interest in CBT as a preferred approach, alternative perspectives might have emerged from the analysis. This does not detract from the participants' accounts of the research phenomenon, but the experiences of trainees with different perspectives may remain under-reported in this study, as well as in the wider literature. It is possible that difference in the attitudes and in the CBT curriculum amongst counselling psychology course providers may have an impact on how trainees perceive CBT. Further studies could helpfully explore whether and how these difference influence a trainee's relationship with CBT's theory and practice, and consequently their professional development and professional identity.

6.2.4 Impact and Importance

Impact and importance relate to how well the research meets the objectives of the analysis, the application it was intended for, and the community for whom the findings were deemed relevant (Yardley, 2000).

A small sample size is thought to be appropriate for an IPA methodology because of its focus on phenomenology and ideographic detail. In this regard the objective was to

produce findings that were unique to the lived experiences of the participants. IPA's ontological position of relativism and its epistemological position of subjectivism does not provide findings that will necessarily be applicable to all trainee counselling psychologists. However, the themes raised by the study are largely consistent with the experiences of other trainees and qualified counselling psychologists, previously reported. Given the importance of CBT to today's counselling psychology curriculum and the proliferation of CBT services, these issues are likely to remain pertinent in the future. It is hoped that the study will be a resource for trainees that wish to explore the literature reviewed and the accounts of some of their contemporaries. In the section that follows, the study also highlights certain areas that may warrant further investigation.

6.3 Conclusions and Recommendations

Looking ahead, CBT will probably continue to be successful as a cost-efficient, short-term treatment. In the public sector, where CBT is a recommended treatment for most common mental health problems, the government is committed to expanding its mental health provisions. In the charitable sector CBT is also likely to be a treatment of choice for organisations that compete for limited funding and where there is need to manage long waiting lists due to demands on their services. In the private sector CBT is expected to remain popular due to its endorsement by health insurance companies. It seems imperative that counselling psychology as a profession continues to engage with, and contribute to, all these services.

The high level of dissatisfaction reported by the participants concerning their training, if common among trainees, may pose a significant challenge in this regard. It is possible that dissatisfaction with academic tuition or clinical supervision could lead trainees to become

disengaged from CBT theory and with the exploration of its diverse practices and applications. Potentially, this could impact negatively on their training in CBT and the quality of CBT they offer clients in these services. It is essential to ask, therefore, how prevalent these concerns are among trainees and what can be done to address them.

It is possible that unrealistic expectations are common among trainees in many different aspects of their professional training in counselling psychology (Efstathiou, 2017; Szymanska 2002). Concerning CBT, this study suggests that trainees may not be fully aware of the need for self-directed learning and continuous professional development beyond their initial course training. It seems that trainees may believe that their occupational training in counselling psychology will provide them with all the expertise they need to practice CBT proficiently. Thus, the distinction and clarity of expectation between 'expertise' and 'working knowledge' may need to be explored more fully. One area that might potentially help, if not being addressed already, would be for courses to provide prospective trainees with clearer information about the range of theoretical and practical skills trainees will need to develop in order to acquire a 'working knowledge' of CBT. Trainees interested in pursuing CBT vocationally might also be better informed about the benefits of acquiring additional training experiences before, during, and after completing their course. While courses may be addressing this issue in different ways, further research is needed to explore the extent of the problem, its potential impact on trainees and the steps that could be taken to redress it.

The participants described aspects of CBT that they enjoyed and which they felt contributed positively to their therapist 'toolbox'. However, based on their placement and supervisory experiences they were sceptical and critical of CBT as an approach. While this

may not be a problem per se, it was associated with frustration and work dissatisfaction during their placements. Furthermore, it appeared to lead some participants to look sceptically at CBT theory in the light of their negative experiences and to conclude that they were a reflection of common practice across a range of CBT services. The dissatisfaction they felt could in part be explained by the 'conflicting paradigms' that sometimes existed between themselves and their CBT supervisors concerning the best way to conduct therapy. As previously reported by trainees and qualified counselling psychologists in other studies, this difference in perspectives was attributed to the participants' belief that counselling psychology values should be expressed in their work.

However, many of the participants' concerns could be attributed to their supervisors' guidance or to their placements' operating policies and procedures. These concerns, often perceived to be commonplace in other services, were frequently presented as evidence of problems with CBT itself. This possible conflation between specific concerns about CBT practice and its general use appeared to shape the participants' perceptions of CBT. Courses could possibly help trainees to look further at how different practitioners and services interpret and implement CBT's theory in practice. In turn this might enable trainees to achieve a greater appreciation of the diverse ways CBT can be practised, and a critical appraisal of how supervisors or placements are applying CBT and promoting its best practice.

Negative supervisory experiences were the focal point of much of the participants' criticism, but the perspectives of their supervisors on issues such as pluralism and the role of the therapeutic relationship was beyond the scope of this study. It is possible that some CBT supervisors may place less emphasis on the therapeutic relationship than do others.

Given the importance to trainees of their professional values, this may have influenced their perception and experience of CBT. Thus, it could help trainees to achieve greater satisfaction in their work if they were able to establish a shared understanding with their supervisors. Further research on the extent to which trainees express concerns in this area, as well as the views of CBT supervisors on the 'working alliance' and the use of PCT and PDT concepts when conceptualising the therapeutic relationship could be helpful. Given the reported benefits of addressing the therapeutic relationship as a key determinant of positive outcomes for clients, the pluralistic training of counselling psychology places trainees in a strong position to contribute positively to the current theory and practice of CBT. We need to ensure that we are making the most of this opportunity.

6.4 Autobiographical Reflection

At the time of conducting the interviews the participants and the researcher were nearing the end of their professional training in counselling psychology. This study has captured a stage of our professional development when we and other trainees are likely reflecting critically on our training as we look forward to starting a career as a counselling psychologist. At this stage, with only the final evaluative elements of the course to be completed and the imminent prospect of proving our worth to prospective employers, the need to demonstrate professional competence appears to reach a crescendo. The study highlighted that trainees may hold a common misconception that they will be 'experts' by the end of their training. An unintended consequence of this may be that trainees perceive there may be little left for them to learn. To a certain extent with several years of clinical experience in CBT as a trainee, I shared this misconception. However, the participants in this study have deepened my appreciation of the nuances and complexities in the means by which CBT can be practised. The critical literature review also highlighted exciting

developments in the third wave movement of CBT, especially those concerning the role of the therapeutic relationship in CBT that I plan to study next. While the evaluative elements of the course may be a necessity, they may also be distracting trainees from what is arguably the ultimate aim of our education: the pursuit of knowledge through life-long learning. Only through such a commitment can trainees become counselling psychologists able to adapt to a changing landscape of mental health provisions and to place themselves in a position to provide the best possible care for their clients.

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APPENDICES

Appendix A: Interview Schedule

Welcome and briefing of participant by researcher:

Briefing (presenting and discussing the information sheet again)

House rules (phone on silent, emergency exits, etc.)

Review of information sheet

Informed consent

Questions:

1 **Please can you briefly describe/ outline your clinical placements undertaken as part of your counselling psychology training**

2 **Please tell me what led you to seek your CBT placements.**

3 **How have you experience working with CBT within your role as a counselling psychology trainee?**

4 **What, if anything, have you enjoyed or valued in these CBT experiences?**

5 **What, if anything, did you find challenging or difficult in these CBT experiences?**

6 **How do you view your CBT work as a counselling psychology trainee? Prompt – similar to or different from other therapists working with CBT?**

7 **Can you please describe, the role/influence of your course teaching staff in your CBT experiences?**

8 **Can you please describe, the role/influence of your supervisors in your CBT experiences?**

9 **What role might CBT play in your career plans for the future?**

10 **What if anything would you recommend to help counselling psychology trainees when working with CBT in their placements in the future.**

Prompts

Can you help me to understand that more?

How did you feel/ think/ react when and where?

Can you please expand on that?

How was that different?

What advice or support did you receive, if you did?

11 Follow up questions:

Is there anything you would like to talk about that we did not cover in the interview?

Participants will then be given a debriefing sheet, a distress protocol, and a demographic questionnaire to complete

Appendix B: Information sheet

Topic: The experience of trainee counselling psychologists in their cognitive behavioural therapy placements.

Dear Reader,

My name is Andrew Hedley and I am conducting research on how trainee Counselling Psychologists experience their CBT placements during training. This research is conducted as part of my Professional Doctorate in Counselling Psychology at London Metropolitan University, where I am supervised by Dr Angela Loulopoulou

I am writing to request your help in the form of participation. Inclusion criterion for the study:

1. You are currently in your final year of counselling psychology training for a professional doctorate in England.

2. You have undertaken at least two CBT placement during your training.

The purpose of the study is to gain a greater understanding of how trainee counselling psychologists experience their placements in CBT. It is expected that this research project may inform other trainees and the profession of counselling psychology about the contemporary context of CBT placements within counselling psychology training.

Participation: If you consent to participate in this research an interview lasting approximately 1hour will be audio recorded for transcription, with an additional 30mins to cover briefing and debriefing. The interview will be semi-structured to allow for follow-up questions based on the answers given. You will also be asked for some demographical information. Your participation is entirely voluntary and if you decide for any reason that you would like to withdraw from the research before, or during the interview process. After the interview you will be afforded the same rights up to the date when the data from the interviews has been analysed (around March 2017). During the interview participants are not obliged to answer any question they are not comfortable with; and will be allowed to stop or pause the interview, without consequence or need for explanation in the case of any distress or discomfort. Furthermore, electronic audio and transcribed data will only be kept as long as necessary (5 years for the purpose of publication) and will then be destroyed.

Costs: The interviews will be conducted at London Metropolitan University or an alternative arranged location. Interviewing via Skype is also an option. Although no financial incentives can be offered travelling costs to the interview will be reimbursed and refreshments offered.

Confidentiality: Before starting the interview you will be asked to sign a consent form allowing for the audio recording and the use of the material for research purposes. Following the guidelines of the British Psychological Society's Ethical Principles for Conducting Research with Human Participants (2009) your confidentiality and anonymity will be respected. This includes storing your data securely and safely, with personal information and audio recording kept separately, and anonymising any personal information in any published work. A participant’s personal information such as their

name, age, contact details and other identifiable information will be kept separate from audio recordings and held securely. Audio recordings will be stored on computer folder that is password protected in line with Data Protection Act (2012) and the (BPS, 2014). Consent forms containing personal information will be stored physically in a locked secure safe box. Identifiable information such as participants' names, specific details of placements and cases discussed will be removed from the written report in order to protect the identity of participants and others mentioned in the research. Limitations to confidentiality includes any disclosure by the participant of any unlawful behaviour such as breaches in national security and any indicated risk of harm to self or others. Electronic audio and transcribed data will only be kept as long as necessary (5 years for the purpose of publication).

Risks: If during the research you feel uncomfortable answering a question you are under no obligation to and may decline to answer. If you feel that you are expressing any distress we can stop the interview and take a break or stop the interview if necessary. In such situations information will be provided for additional support that can be accessed after the interview.

Making a complaint: Please contact my Research Supervisor to address grievances; a.loulopoulou@londonmet.ac.uk Dr Angela Loulopoulou London Metropolitan University

Please consider seriously whether you can help with this important research. Should you wish to take part or have any further questions regarding this research project, please do not hesitate to contact me on the address below.

Researcher: Andrew Hedley Email: anh173@my.londonmet.ac.uk

Appendix C: IPA Steps 1–3 with extracts from the participants' transcripts

Extract from Amy's transcript

Step 3: Developing emergent themes	Step 1: Reading and re-reading	Step 2: Initial noting
My Question	667 P1 Well, I have had…I've have had colleagues who've done IAPT training.	(667-70) (c) question asked was about sense of professional identity as counselling psychology trainee in your placements?
	668 R1 Mm-hm.	
	669 P1 And it is really rigorous, it's really robust. Um and I compare what…you	
	670 know, what my colleagues have told me they've been through in their training	
- Unmet Needs - CBT training on course seen as inferior to other courses (IAPT)	671 compared to what we get. There is no comparison, you know, in terms of the…you	(671-81) (c) didn't answer the question directly, returned to critique of cbt content of course. (671) others IAPT training or branded CBT trainings are really hard and they're very closely scrutinised and very closely examined. "We get none of that in counselling psychology"
	672 know, the level of…the level of scrutiny that someone's practice can go through in an	
	673 IAPT training and…and…or other sort of branded CBT trainings.	
	674 R1 Mm-hm.	
	675 P1 You know, they are really worked hard and they're very closely scrutinised and very	
	676 closely examined. We get none of that in counselling psychology.	
	677 R1 And do you think that's a good thing or a bad thing?	
	678 P1 I think if you're going to say that you've learned CBT…	
	679 R1 Mm-hm.	
	680 P1 …as counselling psychologists do…	
	681 R1 Mm-hm.	
- Unmet Needs - CBT Knowledge From Course	682 P1 …and you actually look at the quality of the training that they've had…	(c) repeating message that the course was seen as poor relative to other CBT
	683 R1 Yeah.	
	684 P1 …and the quality of…the level of scrutiny that their practice has undergone,	
	685 versus somebody who has taken a properly branded CBT training.	

lacking in instruction and scrutiny	686 R1 Mm-hm.	training courses
	687 P1 …I suppose I have concerns about…about…I can only speak about our	
	688 program.	
	689 R1 Yeah, yeah. Of course, yeah.	
Critical of CBT training on course seen as less than? In both knowledge and theoretical groundedness	690 P1 People coming out saying I'm CBT informed…	(c) 'CBT informed' sarcastic comment? Suggests that course is not producing CBT therapists but trainees are suggesting/ implying they are doing CBT?
	691 R1 Mm-hm.	
	692 P1 What does that actually mean? And what does it say about the…about	
	693 the…the quality and the knowledgeableness and the theoretical groundedness	
	694 of your practice as a CBT practitioner…	
	695 R1 Yeah.	
	696 P1 …compared to somebody who has properly studied CBT?	
	697 R1 I'm wondering if…if then in terms of comparing your work as a trainee…a	
	698 counselling psychology trainee doing CBT…	
	699 P1 Mm-hm.	
	700 R1 …are you sort of saying that you feel that your training is maybe less than?	
	701 P1 Yeah.	
Clinical Practice And Professional Development	702 R1 Okay.	(702-8) course cbt seen as less than. "Well, why call it CBT?" …"it's bits and bobs of CBT techniques"
	703 P1 Way way less than.	
	704 R1 Is there any (laughter)…any…is there any benefits at all, do you think maybe	
	705 for having a less CBT focused training?	

Extract from Becky's transcript

Step 3: Developing emergent themes	Step 1: Reading and re-reading	Step 2: Initial noting
	671 R1 So what role…my question is what role do you think CBT might have, then, moving forward in	My question role CBT might have in future/ career plans?
	672 your future career as you go forward with…with things?	
Changing Views about CBT - Gained Through Understanding CBT and its logic	673 P2 I think it will have a big…I think it will have a big role…	(673) a 'big role' (c) she is describing how her perspective has changed during her training. "understand the logic behind CBT"
	674 R1 Mm-hm.	
	675 P2 …because of my own approach mentally to CBT in comparison to…to where I was in the	
	676 beginning, I…I would say. And I feel that if I think about myself in the first year, I didn't like CBT, I	
	677 didn't quite enjoy doing CBT.	
	678 R1 Mm-hm.	
	679 P2 And…and I still come back to the homework aspect of it. But as I've moved on into my third	
	680 year, I feel that I'm now incorporating more and more CBT, I am understanding the…the…the logic	
	681 behind CBT…	
	682 R1 Mm-hm.	
Knowledge - CBT Effectiveness on self	683 P2 …because I use it on myself every day as well, you know.	(683) Sees the personal value in CBT in self-therapy.
	684 R1 Okay.	
CBT Theory Seen As Accessible to learn	685 P2 And…and by using it on my own, whether it's a thought when you're ruminating, you…you…I	(685-688) CBT is seen as a therapy that is easy to access and to learn (independent
	686 stop, take a breath now, where did that thought come from, you know. I'm able to	

independently	understand it. So 687 I feel that as…as I move on and reading more around the…the topic, understanding CBT, I feel that I	learning).
Learning CBT as a secondary model - challenges	688 will use CBT I think a lot more than I thought I would have, say, two years ago…. 689 R1 Okay. 690 P2 …because I'm using it a lot more now than I would say in my first year when I was training. 691 R1 And I guess alongside that then, you know, because you mentioned the psychodynamic, do 692 you think the psychodynamic will also be a big part? Or is…do you think CBT is…I'm just…you know, 693 moving forward really?	(688) she is willing to use CBT a lot more. Having learnt psychodynamic therapy in the first year
Embodiment Of Professional Values – pluralism ? Integrative stance	694 P2 Yeah, because you're…well, I think it will…they'll both be because you can't just get rid of the 695 one…the other…the one to bring the other up. So I think they will both be part of my…my life, to be 696 honest. 697 R1 Mm-hm.	(694-702) Sees the value of both CBT and psychodynamic in her future practice. "Cant get rid of the one……"
Internalised Working Model - Short-Term Therapy	698 P2 And it's something that I've learned and…but I…and it all depends on the service. 699 R1 Yeah. 700 P2 Psychodynamic, as you know, is…is really for long term work. 701 R1 Yeah.	(698-708) (c) Modality depends on the service. Psychodynamic seen as needing long term therapy and CBT seen as short term therapy.

Extract from Christine's transcript

Step 3: Developing emergent themes	Christine's transcript Step 1: Reading and re-reading	Step 2: Initial noting
My Question 1. Please can you briefly describe all of your placements on your counselling psychology training	1 R1 Okay. So thanks for agreeing to do this. So my first question is, could you 2 just briefly describe, outline, your placements you've taken so far on the 3 course?	(1-3) Question? placements as part of course
Prior Experience Of IAPT/ CBT	4 P3 Yeah, sure. The placements, I started in primary care IAPT, which was 5 about six to eight sessions at XXXXXX in the main role. And then, I was able to take 6 on…because that was my existing job. And I was able to take on extra clients if 7 needed. So that was the first place when…I was a PWP in that service, psychological 8 wellbeing practitioner. 9 R1 Yeah	(4-8) Prior training/ work for IAPT service as PWP
Experience of short-term CBT work	10 P3 So naturally there about half an hour per session for the six to eight and then 11 again I took on placements, we tried to limit it as much as they could to about six to	(10-3) Continuation and further development of role - 30mins to 60mins
Experience/ Interest In Complex Presentations	12 eight sessions for an hour each. And then another placement I had was an IAPT 13 worker in a female custodial establishment.	(12-3) and w/n female custodial est.
Experience of working with complex presentation ? the role of CBT	14 R1 Okay. 15 P3 And again, sessions were limited to an extent, but there was some flexibility 16 'cause a lot of them either had personality disorders as well as the standard anxiety 17 or depression presentations. Or they might, for example, have learning needs, 18 learning disabilities. So there was flexibility on…I often saw people for about 25 19 sessions.	(15-9) more complex presentation (PD & LD)/ required more sessions about 25

	20 R1 Much more…more complex presentations, obviously, then.	
	21 P3 Yeah.	
	22 R1 Um And so, in all of your placements you've done so far, then they've all been	
	23 sort CBT. Is that been kind of the main way of doing it? Model used or…	
Flexibility Over When To Use CBT Or Not/ Client groups/ Hospice setting? CBT not valued as much	24 P3 They were a couple of other placements, like a hospice I…I worked. That was	(24) Placement with a hospice (could use CBT or any model/ or integrative
	25 quite flexible. You could do CBT or any model you wanted. Or integrative. And	
	26 then, another placement I had for the first year…'cause that's where we mainly	
Challenges of using CBT when taught other models alongside integration	27 trained in our course. We were mainly trained in CBT in the first year, being afraid	(27) originally trained in CBT 'being afraid to use CBT initially' ? even with IAPT PWP experience – reference to 'we' not 'I'
	28 to use CBT initially. But actually when we learned the other models as well, then	
	29 they encourage us to use them and then integrate them more as well.	
	30 R1 Right. Okay. Maybe we could, like, come back to that other stuff later on.	
	31 P3 Yep.	
Question 2. Please tell me what led you to seek these CBT placements.	32 R1 Say, it was…was there anything that you could tell me that would draw you to	(32) Question what drew you to these placements?
	33 working in those areas where you were doing CBT?	
Prior Knowledge About CBT	34 P3 I think what drew me into the areas…I think the CBT was something that I've	(34-7) Building on previous experiences/ knowledge 'genuinely interested' 'knew the model reasonably well'
	35 been trained in an extent with doing the PWP course so it was something I was	
	36 genuinely interested in because I…I knew the model reasonably well. Initially, it felt	
	37 quite safe and comfortable 'cause it was something that you knew really well. So I	

Extract from Danielle's transcript

Step 3: Developing emergent themes	Step 1: Reading and re-reading	Step 2: Initial noting
My Question	441 R1 My next question, we've...you know, you've mentioned quite a lot of things,	(441-4) Question ref challenges or difficulties with working with CBT
	442 so maybe...just if you want to mention something that you haven't already about	
	443 what if anything you found challenging or difficult with...in your CBT experiences?	
CBT Places Unrealistic Expectations On Clients	444 P4 I guess the overall thing as I mention quite a lot of them is the, sort of,	(444) CBT seen as placing responsibility on clients to change 'internalisation of responsibilities' in terms of 'distress and ways of approaching it'
	445 internalisation of responsibility that CBT promotes when it comes down to clients'	
	446 distress and ways of approaching it. And thinking back of how, you know,	
	447 counselling psychology is meant to be non-oppressive, non-discriminatory, non...I	
Importance of counselling psychology values – respect for clients' autonomy/ diversity	448 don't know...inclusive on where everyone is	(449-50) 'That's where I disagree with it' (c) described as counter to CoP roots 'non-oppressive, non-discriminatory' 'inclusive'
	449 I think CBT actually sometimes emphasizes the responsibility of the	
	450 individual and that's where I disagree with it.	
CBT- weaknesses of approach – assigning responsibility inappropriately	451 R1 So it's...what I think you said earlier it's kind of like saying that they...you're	(c) ? over whether this is good CBT practice? – idea that CBT places responsibility on individual
	452 telling the client they've got the problem and then they...they...they can sort it out	
	453 by doing...	
	454 P4 Yeah. And that's not always true.	
Internal Working Model - CBT Needs To Be Tailored	455 R1 And dare I ask, "how does that make you feel" as...as a therapist in those	(458) at this point of my training 'I just refrain from doing it'
	456 situations?	
	457 P4 Dare you ask? (Laughter)	
	458 P4 I think at this point of my training I just refrain from doing it...	

Working model of how CBT should be conducted - different from what is being expected of her in her placement/ supervision	459 R1 Okay.	(c) adapting therapeutic approach based on experiences - reinforcing that not everything can be tackled in therapy – (bio/psy/social formulation of clients problems)
	460 P4 ...Or before doing something my...actually I...I perceive as attributing the	
	461 responsibility on my client rather than being objective in attributing responsibility. I	
	462 just...I now imagine my, sort of, pie chart and where an aspect of that presentation is	
	463 the client's sort of responsibility to change...	
	464 R1 Okay.	
	465 P4 ...and the rest of it is social factors, environmental factors and all the rest of	
	466 that. And I try to stress to my clients that not everything is their fault...	
	467 R1 Okay.	
Evaluation of CBT- CBT Not For Everyone	468 P4 ...and not everything can be actually tackled through therapy. And	(468-86) not everything ..can be 'tackled through therapy' (realistic expectations) therapy goal is not solution but greater resiliency to the crappy things..need to..face
	469 sometimes the objective of therapy is to make them more resilient to the crappy	
	470 things they need to go out and face. So I guess for me, that's primarily	
Perception that CBT places too much emphasis on treating the individual and not taking a holistic perspective?	471 communicated whenever a client says...what was recently, I had a client that had	(471-86) experience with a client w/ anger issues - moved away from standard protocol to address other's expectations on her. 'other people highlighted her ..problematic and dangerous' focus was on psychoeducation to normalising her experiences.
	472 anger issues, and we were meant to be exploring them. In CBT you worked fine until	
	473 a certain point and I think at some point I noticed that she had the expectation of	
	474 not expressing anger, rather than assertively communicating it or expressing why it is	
	475 that she feels angry. And we explored this certain instance and it came out, using	
	476 the downword-arrow technique, you know, which is another thing I really like using.	

Extract from Ellie's transcript

Step 3: Developing emergent themes	Step 1: Reading and re-reading	Step 2: Initial noting
My question	256 R1 And were they counselling psychology supervisors or were they different?	My question – a follow up on different supervisory experiences?
	257 P5 No. Unfortunately not, no, our clinical psychologists mainly and the CBT	
	258 accredited therapist.	
The salience of the therapeutic relationship – expression of humanistic values. Seen as different to others (Clinical Psychologists)	259 R1 So, the clinical psychologists, how is their supervision, I mean how was that?	(259-65) perception of difference btw CPs CoPs training. . 'lot more aware of the use of self' 'what's going on in the room' CoP vs. CP 'not an awful lot of that' more attuned to 'waiting lists' 'NHS pressures'
	260 P5 Good. Yeah, really good, but I think as counselling psychologists, we get	
	261 trained a lot more. We're kind of a lot more aware of the use of self and what's	
	262 going on in the room and what's coming up for us, and although there's a little bit of	
	263 that coming through from the clinical psychologist, there's not an awful lot of that.	
	264 It tends to be more about kind of waiting lists and how many more we can get, you	
	265 know, NHS pressures.	
Supervisors As Mediators To whether counselling psychology's professional values are discussed/ explored Felt less supported by these CBT supervisors?	266 R1 And, the CBT therapists, CBT supervisor, was that the same sort of thing or…?	(266-74) CBT supervision experienced as a negative 'really didn't like that (CBT) super.' ..'set question' 'set goal' super reflected back 'well, what do you think' (c) unmet needs 'supervision should be to go to speak to somebody…shine new light on something' not spoon-fed 'what would be the CBT protocol' give them diagrams and handouts (implied not
	267 P5 That seems…I really didn't like that supervision. I had to go with a set	
	268 question and a set goal that was tryto get out of the supervision. And, the	
	269 supervision was a lot of her just turning it back to me, "Well, what do you think?	
	270 What do you think?" and I really struggled with that because I believe that	
	271 supervision should be to go to speak to somebody who can give you…shine new light	
	272 on something. Not that I want to be spoon-fed, but I think they should be able to	
	273 shine a new light and then it just kept coming back to,"Well, CBT, what would be the	
	274 protocol?" and given lots of diagrams and handouts and not a lot of else really.	

		what they actually needed)
My question?	275 R1 So, from all that different kinds of CBT supervision from different supervisors,	My question: follow up about different supervisory experiences?
	276 do you think that's…how do you think that might have influenced your work, if at all,	
	277 if it has having different inputs?	
Supervisors offering different focus – providing different learning opportunities?	278 P5 I don't know if I can answer at the moment. I think they probably all had an	(278-82) not sure how different supers with different modalities has influenced (c) still working it out..TO or type of supervision preferred? but, 'prob. all had an impact in a diff. way' 'brought diff. things for me to think about'
	279 impact in a different way. They've all brought different things for me to think about.	
	280 Yeah, so it was sort of how they've influenced my work?	
	281 R1 Well, if they have at all, you know, kind of from having those different kinds	
	282 of supervisions, how that maybe you've...?	
Managing Stress	283 P5 I think, if anything, and this probably isn't what you're looking for, but it's	(283-288) Issue of burnout highlighted by how different supers deal with workload, some ok some stressed out
	284 made really think about burnout, you know, and kind of seeing different supervisors,	
	285 some appearing to be under a lot more pressure than others and perhaps closer to	
	286 burnout and then others that seem to be going along okay and a lot more	
	287 boundaried, it's then you think about what they're doing to keep themselves fresh	
	288 and kind of working professionally.	
External Demands/ Increased Work Demands	289 R1 I mean, that…for me that's really interesting. Just…so could you say maybe a	(291-299) difference between taking on too much responsibility 'cramming in a another one'
	290 little bit more about what those differences might be, do you think, or from your...?	
	291 P5 So, it's quite interesting about these two in particular that were kind of very,	
	292 very stressed and they were the ones that always seemed to be cramming	

Extract from Fiona's transcript

Step 3: Developing emergent themes	Step 1: Reading and re-reading	Step 2: Initial noting
My question?	255 same time needing at times to be a bit more direct, is that…?	My question: follow up on the benefits of being allowed to be more direct in CBT
	256 P6 Yeah, I think so, yeah, yeah, yeah, because I think my…when I think about it in some ways,	
Embodiment Of Professional Values - Saliency of the therapeutic relationship through a pluralistic perspective? Integration of CBT + PCT Need for autonomy over practice/ the freedom to practice CBT the way she thinks is best? Or congruent with her beliefs and experiences	257 like my natural way isn't to be very structured. I don't…like I struggle. With CBT I definitely struggle	(257-72) initially struggled with CBT structured approach, setting agendas, time management of sessions, 'supposed to ..negotiate it at the start' - 'I don't always do that' (c) sees value in having time to explore what a client brings 'rest of it is left a bit open' 'don't think it's been a problem' 'supervisor hasn't had any problem'
	258 with structure. I mean even, someone walks into the room when I…I have an idea of the structure	
	259 and like it just doesn't go, or you know. In CBT you are supposed to kind of say, right, this is what	
	260 we're going to work on today, or, you know, we'll spend like 10 or 15 minutes talking about this or	
	261 we're looking at food diaries you've done, and then I was thinking we could talk about this for 10	
	262 minutes and then you're supposed to kind of negotiate it at the start. I don't always do that and that's	
	263 partly because I don't…like I have…I kind of have to so I say, right, so let's spend 10 minutes looking at	
	264 this, and then you know the rest of it is left a bit open, but never…I don't think it's been a problem. I	
	265 mean I work hard in all of my sessions there actually, so I do listen back to them, so I think I'd notice if	
	266 things were going completely crazy or anything. My supervisor hasn't had any problem with what I'm	

Professional Values – Pluralism ? Integration of CBT + PCT Seen as practicing CBT differently from others – not 'a real CBT therapist'	267 doing. But I'd probably am a good bit looser than a real CBT therapist, but I think…yeah, my nature is	(267-72) see's practice as different 'looser than a real CBT therapist' (c) ? isn't this good CBT practice
	268 just to be a little bit more free flowing about things, and maybe I feel that that is person-centred and	
	269 that that isn't CBT, you know, maybe that's just kind of seeing them as cartoons and just like they're	
	270 completely different. In some way that's my way anyway of being okay with being a counselling	
	271 psychologist and bringing back kind of more humanistic, open, empathetic thing to it, while also doing	
	272 CBT being structured and making sure the work gets done and that kind of thing.	
My Question	273 R1 Could you say what you've enjoyed or valued in your CBT experiences so far?	(273-4) Question what has been valued/ enjoyed in CBT experiences
Strengths of CBT as an approach Sense of Internal Control – autonomy provided/ afforded by practicing CBT as a directive therapy	274 P6 Yeah. Actually to be really honest, I think I like the freedom of being able to question and ask	(274-283) (c) paradoxical position? (more free flowing) but, CBT = 'freedom to ..question' 'permission ..to challenge things' 'gives power actually' 'more freedom ..than PC' 'can be a bad thing'
	275 and point out things that are interesting and just…I actually like being able to…you know, having the	
	276 permission I suppose to challenge things and that's what you should be doing. It's kind of more…yeah,	
	277 I guess more gives power actually, I guess, and more freedom to the therapists than person-centred	
	278 would, which can be a bad thing. But I think when you start doing CBT it is great and it is like, oh well,	

Appendix D: IPA Analysis Step 6 Looking for patterns across cases

Theme1: Pure CBT vs. integration

- Becoming proficient in CBT
- Conflict between external factors & therapeutic control as a trainee
- Lacking confidence in CBT
- Personalising/ tailoring therapy & CBT to the client
- Pressure from placements to only deliver CBT
- Pressures on placement to deliver cost-effective CBT
- Role of supervisor as role model & a gatekeeper
- Type of CBT dependent upon placement and supervisor
- Unmet professional developmental needs

Theme2: CBT conflicts with counselling psychology's values

- CBT not as effective for addressing complexity & severity
- Desire to express professional values through pluralism
- Experience and interest in working with complexity and severe presentations
- Greater control gained through pluralism
- Saliency of the therapeutic relationship for effective therapy
- The importance of the therapeutic relationship to counselling psychology

Theme3: Deconstructing & assimilating CBT

- Autonomy to be directive has unwanted consequences

- Being directive restricts the client's voice/free expression
- Career prospects: personal & professional interest in CBT
- Open & closed to practicing CBT in the future
- The autonomy to be directive in CBT
- Therapeutic power in CBT's interventions
- Understanding of CBT's therapeutic power

Appendix E: Informed consent

A QUALITATIVE STUDY OF HOW COUNSELLING PSYCHOLOGY TRAINEES' EXPERIENCE THEIR CBT PLACEMENTS.

Informed Consent Form -

Name of researcher: Andrew Hedley, Trainee Counselling Psychologist

Contact details of principal researcher: anh173@my.londonmet.ac.uk

To be completed by participant (please initial each box):

I confirm that I have read and understand the participant information sheet for the above study.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time before or during the interview without the need for any explanation or reason. After the interviews, participants will also be afforded the same rights to withdraw, up to the time when their data has been has already been analysed (around March 2017).	
If I withdraw from the study, the data that I have submitted will also be withdrawn at my request.	
I agree to my interview with the researcher being audio recorded.	

Date: _____

Name of participant _____

Signature of participant _____

Signature of researcher _____

Appendix F: Demographics & CBT experience form

A QUALITATIVE STUDY OF HOW COUNSELLING PSYCHOLOGY TRAINEES EXPERIENCE THEIR CBT PLACEMENTS.

Please complete the following information

Demographics	
Name:	
Age:	
Gender:	
Ethnicity (please specify):	

Pre-counselling psychology training experiences of counselling	
Counselling Qualifications	
Training in models of therapy	
Please briefly describe any clinical experiences of counselling prior to starting your counselling psychology training	

Counselling psychology training experience and models of therapy	
Year of training:	
Full time or Part-time Student:	
Place of Training:	
Your training programmes primary model of therapy:	
Secondary model:	
Other models:	

Counselling Psychology training experiences in CBT

*Please describe the criterion that best represents your clinical placements as a counselling psychology trainee in which CBT has been used. Please mark ☒ as appropriate. *page content repeats for those with additional placement experience*

1st Placement	**Clinical setting** IAPT primary ☐ IAPT secondary ☐ IAPT CYP ☐ non-IAPT NHS ☐ primary non-IAPT NHS ☐ secondary non-IAPT NHS ☐ specialist NHS ☐ specialist non-NHS ☐ third sector/voluntary ☐ student counselling ☐ private practice ☐ other ☐ please describe: _____ _____ _____ _____ _____	**Type of CBT used** 1st wave ☐ 2nd wave ☐ 3rd wave ☐ Please describe types of 3rd wave used _____ _____ _____ _____ _____ Protocol ☐ non-protocol ☐ combined approach ☐ other ☐ please describe: _____ _____	**Average number of sessions offered to clients** 6 sessions ☐ 8 sessions ☐ 10 sessions ☐ 12 sessions ☐ 14 sessions ☐ 16 sessions ☐ 18 sessions ☐ 20 sessions ☐ If longer please indicate number of sessions ____ Open ended ☐ Provision to extend ☐
2nd Placement*	**Clinical setting** IAPT primary ☐ IAPT secondary ☐ IAPT CYP ☐ non-IAPT NHS ☐ primary non-IAPT NHS ☐ secondary non-IAPT NHS ☐ specialist NHS ☐ specialist non-NHS ☐ third sector/voluntary ☐ student counselling ☐ private practice ☐ other ☐ please describe: _____ _____ _____ _____ _____	**Type of CBT used** 1st wave ☐ 2nd wave ☐ 3rd wave ☐ Please describe types of 3rd wave used _____ _____ _____ _____ _____ Protocol ☐ non-protocol ☐ combined approach ☐ other ☐ please describe: _____ _____	**Average number of sessions offered to clients** 6 sessions ☐ 8 sessions ☐ 10 sessions ☐ 12 sessions ☐ 14 sessions ☐ 16 sessions ☐ 18 sessions ☐ 20 sessions ☐ If longer please indicate number of sessions ____ Open ended ☐ Provision to extend ☐

Appendix G: Participant Debrief Sheet

A QUALITATIVE STUDY OF HOW COUNSELLING PSYCHOLOGY TRAINEES EXPERIENCE THEIR CBT PLACEMENTS.

Thank you for taking part in the interview and this research project.

When the interview has been transcribed you will be invited to review your transcript with personal identifiable information removed, to ensure the accuracy of its content.

Should you wish to withdraw your submitted data, please contact the researcher via email. (anh173@my.londonmet.ac.uk) up to the date when the data from the interviews has been analysed (around March 2017).

If you wish to make a complaint please contact research supervisor Dr Angela Loulopoulou at London Metropolitan University (a.loulopoulou@londonmet.ac.uk) or if you have any further questions regarding this research project, please contact me directly (anh173@my.londonmet.ac.uk)

Risks: If this study has harmed you in any way, please consult your personal therapist, the London Metropolitan University or your local GP for advice. Additionally, you could contact helplines such as those provided by MIND and the Samaritans whose details are provided below.

MIND
15 -19 Broadway, London, E15 4BQ.
Tel: 03001233393 102085192122
Email: contact@mind.org.uk
Website: www.mind.org.uk
Provides a confidential helpline, face-to-face counselling, advocacy, support and befriending for a broad selection of mental health difficulties.

Samaritans
Tel: 084 5790 9090
Email :jo@samaritans.org.uk
Website: http://www.samaritans.org/
Offers a 24 hour support help-line service.

Thank you,

Andrew Hedley

Counselling Psychologist Trainee

Appendix H: Master Table of Themes Including Sample Quotations

Theme 1. Pure CBT vs. integration	Line reference
1a. Learning CBT where it is practised	
Becky: I feel I just have the basics of CBT	648
Ellie: learn the skills of CBT in an environment where just that is practised	413-4
Fiona: if I didn't have that placement, I wouldn't be competent in my CBT	490
1b. Use CBT and nothing else	
Amy: the students (…) they're like self-healers.	579-81
Beck: homework I really struggled with (that)	573-8
Christine: you get a bit frustrated (with CBT) you can see the limitations	36-40
Danielle: arguing for the sake of my clients that this cannot be done in 8 sessions	175-8
Ellie: supervision was very much, "You will just use CBT and nothing else".	98-101
Fiona: CBT from a person-centred angle (…) didn't go down well (with supervisors)	373-6
1c. No set approach to be followed	
Amy: it's bits and bobs (…) you might throw in your toolkit	710-11
Becky: with (abuse) you're doing psychodynamic, but I (…) assimilate with CBT	40-41
Christine: I assimilated the CBT techniques in …	459-66
Danielle: in an integrated way (…) it was quite easy for me to pull through	508-12
Ellie: (CBT) used in a kind of cherry picking-type way	151-3
Theme 2 CBT conflicts with counselling psychology's values	
2a. CBT sitting alongside other theories	
Amy: never been a therapist who identifies … with a particular model	512-24
Becky: (CBT & PDT) one (…) brings the other up. So I think they will both be part of my... life	694-5
Christine: (Counselling psychologists) have a lot more flexible with their formulations (…) not (…) restricted to working only with one	308-18
Danielle: I would not be using a pure clean cut medical CBT as the solution to everything.	565-6
Ellie: (…) the McDonaldisation of therapy (CBT is) kind of a one size fits all	509-12

Fiona: I approach CBT as another tool, rather than kind of the central tool	383-4
2b. First the relationship, then CBT	
Amy: I do what I see (my approach being) most kind of relationally oriented	512-3, 651
Becky: it was always really (…) building that relationship with this client group	303-5, 561-2
Christine: (see more) what's going on in (…) transference, the attachment style	73-76
Danielle: we really think about ourselves (…) within the therapeutic relationship	460-1
Ellie: it's about building a relationship and then using some of the CBT	372-3
Fiona: bringing (a) more humanistic, open, empathetic thing to (CBT)	269-1
2c. *CBT oversimplifies problems*	
Amy: for fairly straightforward presentations, I think it is a fantastic	642-643
Becky: (CBT) doesn't translate that well (for children)	241-2
Christine: I just found that CBT (…) worked well for (issues) taking place more recently (less useful for issues relating to the past)	408-9
Danielle: I think CBT actually sometimes emphasises the responsibility of the individual (ignoring environmental factors)	449-50
Ellie: I don't think (CBT) can be used in a uniform way, that's just my personal opinion.	142-144
Fiona: CBT just isn't enough (…) CBT formulations … (they don't go) anywhere near enough to explaining (severe presentations)	402-4
Theme 3. Deconstructing & assimilating CBT	
3a. CBT provides structure and permission to challenge	
Amy: they get CBT and (…) they're amazed at how much progress they've been able to make	540-3
Becky: (challenging negative thoughts)...I found that was very fascinating. I enjoyed that	378-90
Christine: can definitely see the results and usually quite quickly as well	96-107
Danielle: (…) immediate improvement people notice and I really like it..	365-6
Ellie: there is great power in writing things down	134-6
Fiona: having the permission (…) to challenge things	275-6
3b. CBT's focus is both its strength and its weakness	

Amy: CBT can be extremely focused but it doesn't necessarily always create space	638-42
Becky: I did struggle with (…) the idea of using CBT when you're looking at historical abuse	414-5
Christine: (it's) about having a bit more flexibility with CBT	471-3
Danielle: CBT is not really the magic solution	325-6
Ellie: unconscious (...) there's no place for it in pure CBT	194-5
Fiona: put people into boxes. (…) over-simplifies their problem	302-6, 417-10
3c. Assimilating CBT	
Amy: think of my practice more as counselling psychology than I do as any particular model	498-9
Becky: I find that I'm always bringing in CBT techniques regardless of the approach I take	555
Christine: So I think (CBT) very much (fits into) (…) assimilated integration.	465-6
Danielle: (I) wouldn't be (working with CBT) unless (…) we're referring to something extremely specific	559-61
Ellie: it's kind of integrating everything about the person …(then sometimes) the practical skills of CBT	360-4
Fiona: I actually really do think CBT is great when (…) used for the appropriate issues	478-9, 457-63