How nurses and other healthcare professionals training in cognitive behavioural therapy experience the challenge of applying new learning in their clinical practice: A grounded theory study.

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A Thesis submitted to the School of Social and Health Sciences, University of Abertay, in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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I certify that this thesis is the true and accurate version of the thesis approved by the examiners.

Signed .... [redacted] (Director of Studies)

Date.....11.10.07...

PhD requirements of the study.

This thesis will be submitted to the School of Social and Health Sciences, University of Abertay, in partial fulfillment of the requirements for the degree of Doctor of Philosophy. The University of Abertay Research Degrees Handbook (2000) states that: *The degree of doctor of philosophy (PhD) or doctor of business administration (DBA) shall be awarded to a research degree student who, having critically investigated and evaluated an approved topic resulting in an independent and original contribution to knowledge, and demonstrated an understanding of research methods appropriate to the chosen field, has presented and defended a thesis by oral examination to the satisfaction of the examiners.*

Accordingly, this document has to fulfil two equally important, separate but complimentary criteria: Firstly to provide an accurate account of a research project which is of scientific relevance to the wider research community and secondly to demonstrate the aforementioned criteria of critical evaluation, contribution to knowledge and understanding of methodology to a standard meritorious of the degree of doctor of philosophy.

Declaration

I, Stephen N. Martin, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed ..... 

Date .....02/10/07.....

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Abstract

In this qualitative study, three cohorts comprising mainly registered mental nurses and one of graduate occupational therapists were interviewed concerning their experiences of attempting to apply recently delivered cognitive behavioural therapy (CBT) training in their routine clinical practice. Additionally, four respondents from nursing, medical, clinical psychology and occupational therapy backgrounds undertaking an award-bearing diploma level course in CBT were interviewed for the purpose of enhancing the depth and completeness of the study.

The training consisted of four series of six half-day workshops covering the basics of the theory and application of CBT. The research participants, who comprised the subset of the total from the cohorts sampled for the research, plus the additional four respondents, worked in a variety of mainly mental health hospital, in-patient, community and day clinic settings.

The main aim of the study was to gain understanding of how the research participants experienced the challenge of applying the training to their clinical practice.

The interviews were audiotaped then transcribed providing a basis for a grounded theory analysis of the research data. The analysis was cumulative in that the findings from the analysis of each new cohort was integrated into that from the previous findings. The findings from the occupational therapist cohort were analysed separately. Five main categories were identified: the core category of '*on the threshold*' along with other four other categories: '*negative thinking*'; '*overcoming difficulties*'; '*identity and relevance issues*', and finally, '*understanding and cognitive change*'.

The results of the study confirmed findings from the existing literature that external, environmental deficiencies in the workplace could act as a barrier to training transfer. The results also however offered fresh insight into how *internal*, cognitive factors with their origins in role identity dissonance could equally act as a barrier to training transfer.

There was also evidence that some research participants were able to devise and utilize implicit strategies to overcome such barriers. These internal barriers to training transfer, their cognitive origins and behavioural consequences along with a description of the strategies some participants used to overcome them, were conceptualised using a cognitive-behavioural framework.

The study concludes by suggesting that there are grounds to believe that these findings might be used to illuminate and address internal barriers to the transfer of training during, and as part of a self-reflective component of future training interventions, facilitating the application of the teaching to the clinical domain.

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Chapter 1: Introduction and orientation to the study

1.1: Introduction to the chapter

The purpose of this chapter is to orientate the reader to both the study and to the structure of this thesis. The foreword introduces the thesis to the reader and explains its construction and progression in four parts. The study aims and goals of the research provide the reader with an understanding of the main questions which the research is designed to answer as well as a grasp of the scope and intention of the research project. Consistent with the emergent grounded theory methodology employed within the study an initial or *a priori* literature review is also included in this chapter to sensitise the reader to the background concepts and themes which inform the overall research problem.

1.2: Foreword to the study

This thesis is an account of the research undertaken by this author into aspects of the teaching component of my role as a clinical nurse specialist (cognitive-behavioural psychotherapy). The study began on a part-time basis in the year 2000 and was partly funded by my employer, Tayside Primary Care NHS Trust, and partly by myself. The study is a field study, utilising a naturalistic paradigm and combining grounded theory and action research methodologies. This author was the sole researcher involved with the study throughout its duration. The thesis is effectively divided into four parts:

Part one orientates the reader to the study and includes the foreword, study aims and contains the initial literature review.

Part two of the thesis describes the scientific basis of the concepts and methodologies, which underlie the design and conduct of the study. In the research design chapter the theoretical basis for the methodologies and concepts used are elucidated and justifications are presented for their inclusion within the study. In the Methods Chapter a description is provided of how these methodologies are actually applied in the practical conduct of the research. In

the methodological considerations chapter consideration is given to the strategies utilised in order to maximise the integrity of the study.

Part three of the thesis presents the results of the grounded theory analysis of the research data. Five main categories are described and there is frequent use of direct reference to the raw research data to a) support the conceptual analysis and b) to provide the reader with a rich and vivid account of the phenomenon under study.

Part four of the thesis contains the main literature review and presents the conclusions to the study, where the study is summarised, its limitations are considered and possible related directions for future research are explored.

Chapter 6 of the thesis sits outside the structure described above and might at first glance appear somewhat anomalous. The main body of the research described above refers to the experiences of three cohorts comprising mainly registered mental nurses. One additional cohort of graduate occupational therapists was also however included in the study. This cohort is included here as a separate 'study within a study' due to its utility as a means of enhancing the reliability and validity of the study through data-source triangulation.

1.3: Study aims and goals of the research

1.3.1: Study aims

The aims of this study are twofold:

Firstly to explore and create new knowledge which would illuminate the main research question for this study, namely: *how do nurses training in cognitive-behavioural therapy experience the task of trying to apply that training in their routine clinical practice?*

Secondly, this research will of benefit to the trainees who will attend subsequent, similar workshops I intend to run, as well as having a generalised effect in the wider field of training healthcare professionals in psychotherapy techniques. It is this researchers intention to incorporate emergent theory and understanding from the research into subsequent teaching interventions so that this understanding might be used in effect to pre-emptively address potential barriers to training transfer before they arise, in effect, an action research cycle

after Lewin (1947). It is anticipated that the first few cycles of this process might not yield immediate benefit to the learners whilst knowledge and understanding was being developed, but would contribute to a gradual development and refinement of theory, which ***would*** ultimately enhance the teaching itself.

1.3.2: Research goals

In the conduct of this study, two main research questions will be answered:

1: How do the research participants experience the challenge of applying CBT training in their clinical practice?
2: What role do the research participants own emotional and cognitive processes play in how they experience the challenge?
3: Is there a model, which might authentically represent the research participants' experiences as a process?

1.4: A priori literature review

1.4.1: Introduction to the section

This a priori or initial literature review establishes the broad area of the research namely the established need for greater understanding of the link between CPD and change of practice in nursing. The expansion of mental health nurses into psychotherapy training is described and the relative paucity of data concerning potential internal, cognitive and affective mediators between training and change of practice is established. Additionally in this section the reader is introduced to the historical and political context of the changing role of nurses and is also familiarised with the existing research studies describing the history and experiences of nurses training specifically to deliver psychological interventions. Finally this section of the thesis will orientate the reader to both the cognitive-behavioural model as well as to cognitive-behavioural therapy both of which are concepts at the core of this study.

1.4.2: Orientation to the study problem area

The need for further exploration of the link between continuing professional development and change in nurses' clinical practice in is well established in current nursing literature (Warmuth, 1987; Ferguson, 1994; Jordan, 1998, 2000;). Traditionally, evaluations of continuing professional development activities have either concentrated on meeting educational objectives such as content evaluation (Crotty & Bignall, 1988) or on learner satisfaction (Ferguson, 1994). Increasingly however it is being recognised that the focus of evaluation must include whether or not the educational event actually impacts upon nurses' behaviour, thus leading to improved patient outcomes. (Gosnell, 1984; Fleck & Fyffe, 1997,). Research is now examining exactly what then mediates between learning and its application in the clinical setting (Waddell, 1993; Hardwick & Jordan, 2002).

The most plausible conceptual framework for evaluating the impact of CPD on nursing practice, Cervero (1985) suggests four sources of variance in clinical application including the learning activity itself, namely:

- Characteristics of the learner
- The environment
- The nature of the change, and
- The CPD offering itself.

Robinson (1977, p.59) summarises: "*The controlling variables actually become the health setting and the individual learners-what they do with the learning, the extent to which they are encouraged and able to perform.*"

Environmental issues or barriers to change, understandably perhaps, have been the most comprehensively explored (Corrigan et al, 1992; Scheller, 1993). In these studies themes such as lack of leadership, incongruity between the values suggested by the continuing professional development and the clinical area and poor staffing levels are a small example of issues uncovered.

It is of course an artificial distinction to view the learner and his/her clinical environment as separate areas for exploration. Cervero (1985) locates behaviour

change within a social system which itself will exert a large influence on how and if a learner changes behaviour as the learner interacts with it. Milne (1984) has suggested that training transfer might be enhanced if the continuing professional development is altered to increase what he calls the 'social validity' of the event.

Other researchers have begun to explore what might be described as the internal variables or learner characteristics, which influence behaviour change. Warmuth (1987, p.5) suggesting that: "*Nursing is not the process of acquiring a piece of information in one setting and then directly, completely and correctly implementing that in practice. It is a humanistic process, it requires judgement.*"

Motivation is one factor, which has been identified as an important variable (Cervero et al, 1986; Warmuth, 1987). There has been little research however into further understanding learners' motivation, particularly what influences this. The literature does hint at a need for nurses to feel secure and supported in the change (Weiss et al, 1980), whilst Horn (1976) makes reference to the need for the right "job climate". Jordan (1998) argues for the need for learners to be allowed to test the validity of classroom theories in their clinical areas and Warmuth (1987) identifies the element of risk-taking in implementing a new approach. Scheller (1993) went so far as to suggest that it was a nurse's perception of threat from their environment, which acted as a barrier to change.

Motivation is not however a constant, located somehow within the individual and uniform across situations. It varies according to how one perceives a situation with particular emphasis on one's beliefs about oneself and one's environment (Miller & Rollnick, 1991). What Miller and Rollnick are saying in effect is that motivation depends largely on the individual's perception of the costs and benefits of a given situation.

Taken together, this above-quoted research suggests that negative feelings within the nurses, created by the perception that events related to the prospect of applying their training, may well be adversely impinging on the personal domain (Beck, 1976) and acting as a significant variable in training transfer.

This effectively echoes Kurt Lewin's (1951) view of the learner as a purposive person whose view of reality lies in the perception of an event rather than within the external event itself where the reality of an event for that person consists of

the individual's interpretations of the surroundings and the interaction within those surroundings.

If both Lewin's vision of the learner, and Beck's emphasis on the centrality of the individual's own interpretation of events are accepted, then all these variables which have variously been investigated in relation to their impact on training transfer become of secondary importance as they ultimately pass through the lens of the unique meaning each learner ascribes to his situation.

According to the cognitive behavioural theory of Beck (1967), this individual meaning will lead to a particular emotional response which will in turn influence that individual's behaviour. The implications of this for transfer of training are clear. If a learner perceives potential threat or loss whilst contemplating applying what he or she has learned in the clinical setting, then the emotional response may well be negative such as anxiety or disquiet. The most common behavioural consequences of negative emotions are to withdraw from the situation that is perceived as causing them, avoid it altogether or delay and procrastinate (Blackburn & Davidson, 1990).

These issues have been partially explored in relation to therapist/counsellor training. Hogan (1964, p.140) in a paper describing psychotherapist development referred to a stage where the therapists were "*insecure, neurosis bound and dependant*".

More recently Mackay et al (2001, p.32) explored how counsellors experienced changing their model of therapy, and identified the emergence of "*difficult feelings*" and the process of working through these as a central issue. There has however been no similar exploration of nurses training in CBT, nor have these studies looked behind the "*neurosis*" or "*difficult feelings*" to locate them within the context of particular belief systems, explore their cognitive origins or what strategies learners might employ to resolve them.

1.4.3: Background to the study

There are now some 25 award-bearing UK courses in cognitive behavioural therapy (CBT) listed in the British Association of Behavioural and Cognitive Psychotherapies (BABCP) database. These courses range from diploma to masters level, and many have been established for in excess of 10 years now. In

the Dundee University course some 70% of students have come from a nursing background with a figure of 28% for the Newcastle University diploma for the years 1990-95 (Ashworth et al, 1999). These formal award bearing courses are however only the tip of the iceberg with strategic health authorities, healthcare trusts teaching hospitals and others responding to the increasingly well established efficacy of CBT (Stein & Lambert, 1995) by offering a variety of less formal CBT training to nursing staff, both general and mental health. 73% of students questioned for the Ashworth study had attended CBT workshops or training days prior to the Diploma course.

Studies into the impact of training in formal psychological interventions such as CBT are sparse. The Ashworth study looked at the issues of satisfaction with the course and the use of cognitive therapy subsequent to the course. The study reported impressive results in students using CBT techniques subsequent to the course. Some 71% of nursing graduates of the course reported regularly carrying out CBT formulations (a core activity in CBT) with patients in their clinical work. Fadden (1997) looked at nurses training in family interventions for schizophrenia reporting that most subjects highlighted environmental barriers to training transfer such as lack of time or shortage of suitable families to work with.

This focus of the existing literature on environmental barriers to training transfer i.e. external as opposed to internal, continues in Corrigan et al (1992) where five constructs are identified, four of which are essentially environmental, with only "Philosophical Opposition" even acknowledging the possibility of internal mediating factors.

Milne et al (2002) evaluated the inclusion of a relapse prevention module in a multi-disciplinary teaching intervention for psychosocial interventions for severe mental illness. This study found that the relapse prevention module, which specifically highlighted potential barriers to training transfer, did appear to enhance this. The module built on the work of Marx, (1986) and made some reference to the deleterious effects of emotional reactions to perceived failure such as self-blame, unhelpful perfectionism and the need of trainees to self-reward in the absence of organisational support. Bennet-Levy et al (2001) studied the usefulness of trainee cognitive therapists using cognitive therapy techniques on themselves. They found evidence that understanding of the

model; understanding of the therapists' role and empathy with the patients could be enhanced using self-reflexive cognitive therapy techniques. The study stopped short however of encouraging the trainee therapists to develop insight into and perhaps challenge any negative thoughts, which they might have had concerning the challenge of providing cognitive therapy.

This study is therefore intended to explore those aspects of training transfer, primarily with regard to nurses training in CBT which to date remain ill-served by the existing literature, namely the role of internal, cognitive and emotional mediating factors in the process of transfer of CBT training to the clinical environment.

1.4.4: The political and historical context of the nurses' experiences

1.4.4.1: Introduction

Both from personal experience of twenty one years as a nurse and also anecdotally from listening to the daily coffee break conversations of friends and colleagues, it would appear that nursing as a profession is currently experiencing a period of unprecedented, and at its core politically driven, change. A cursory scan of the nursing journals, a tally of the number of policy reviews and initiatives announced by the Department of Health, a search through the Royal College of Nursing's website or even a trawl of the broadsheet newspapers would seem to lend objective credence to this subjective first impression (Department of Health 2002, Dimond, 2006).

Given that the nurses' experiences in this study occur primarily in the context of demands being made of them to expand their role then it is necessary to contextualise this for the reader within the pressure and demands being made of the nursing profession as a whole at a national level at this current time, and also to consider how the profession has developed and is continuing to develop over time.

In this section therefore, a brief account of the political history of mental health nursing will be provided, some of the most pertinent issues in the current political climate surrounding nursing, in particular mental health nursing, will

be listed and reviewed and these will be related to the issues surrounding identity and role dissonance raised by this study.

1.4.4.2: The history of mental health nursing as a profession in the United Kingdom

The profession of mental health nursing grew out of the asylum system of the late 18th and early 19th century. Mental health nurses at the time were known as 'attendants' and were strictly controlled by the doctors in charge of the asylums known as 'superintendents' who were in effect the forerunners of psychiatrists. Interestingly the title of Physician Superintendent remained, albeit as a largely honorary title, in the psychiatric hospital where I was based as late as the 1980's. The changing relationship and power dynamic between psychiatrists and mental health nurses over the last 100 years effectively parallels the story of the development of mental health nursing as a legitimate profession in its own right (Brimblecombe, 2005).

The superintendents in these institutions established a position for themselves whereby only they could lay claim to having the expertise to properly care for the mentally ill (Jones, 1993) which in turn translated to a position of authority which was generally absolute (Gittins, 1998). This absolute authority also shaped the relationship between the superintendents and their attendants even extending to requirement of a superintendent's permission for an attendant to marry (Brimblecombe, 2005). Rulebooks, inevitably written by the medical superintendents gave legitimacy to the control they exerted over the attendants, referring to the need for "*Iron rod discipline*" (Haw 1990, p. 49) which they justified in terms of the need to protect the patients from abuse from morally lax attendants who were considered by some simply to be "*the unemployed of other professions*" (Browne, 1837, p.69).

The first formal and recognized training for these attendants, affording them the status of 'mental nurses' was instigated by the Medico-Psychological Association in 1890. Significantly it was the doctors themselves who instigated this training as it would undoubtedly reflect well on them to require skilled and trained assistants to do their bidding (Brimblecombe, 2005). The training however still reflected this well-established power dynamic between the two

groups with the training manual (the famous 'red book') of 1909 stating that the purpose of said training was to "aid the assistants to carry out the orders of the physicians" (Medico-Psychological Association. 1909, p. ix).

The second half of the 20th century saw the gradual emergence of mental health nursing as a profession in its own right from the shadow of medical domination. The creation of the National Health Service (NHS) in 1948 reduced the power of the physician superintendent largely through the creation of the role of the consultant psychiatrist. The Mental Health Act (England and Wales) 1959 actually removed the statutory need for physician superintendents, and with the Salmon Report (Ministry of Health, 1966) it was explicitly stated for the first time that nurses were in fact directly accountable to their own nurse managers and not to doctors.

Arguably the biggest driving force in the establishment of truly professional status for mental health nursing has been the move away from the institution to community care as the environment where mental health nursing is most often practiced. Whilst the first publicly proclaimed intention to move mental health care to community settings came in 1961 with the then Minister of Health, Enoch Powell's famous 'Water Tower' speech, little actually changed over the next 20 years apart from a few psychiatric wings being added to general hospitals. In 1977 there were still only 1000 community psychiatric nurses (CPNs) in the United Kingdom (DHSS, 1980). In 1977 however the NHS act was introduced, with Section 28a intended primarily to assist with the re-provision of mental health services from NHS long-stay psychiatric hospitals to newly developed services in the community. The Mental Health Act (1983) then imposed a legal duty on district health authorities and social services departments (in co-operation with voluntary agencies) to provide after-care services for people discharged from hospital. In 1989 the government introduced a white paper 'Caring for People' which was a direct response to the previous years Griffiths report (Griffiths, 1988). In it a framework was set out whereby local authorities would be given the responsibility and funding for community care with the core philosophy of facilitating people with needs (including mental health) to be able to live as independently as possible, ideally in their own homes.

So extensive has this transfer now been that in 1992 it was estimated that 95% of people now had their mental health care needs met in the community (Goldberg & Huxley, 1992). What this change in service delivery has meant for the role and identity of the mental health nurse is growing independence from both the influence of the psychiatrist and from the medical model in general, as both are in effect physically left behind in hospitals and institutions. Nurses working in the community inevitably took on greater autonomy and decision-making powers, commonly accepting direct referrals from GPs, autonomously implementing treatment plans based on evidence based studies of efficacy and playing an equal part in multidisciplinary decision making processes.

1.4.4.3: Current political influences on the nurses' role within the healthcare system

A second profound influence of the development of the nurses' role has been the search for relatively low cost solutions to political imperatives such as the reduction of waiting times (DoH, 2000) the increasing influence of the demands of service users on health care provision (Rose 1998, The NHS & Community Care Act, 1990), formally acknowledged in the Patients Charter (1991) and the pressure to reduce junior doctors hours (Magennis et al, 1999). The nurses' unique position and status within the healthcare 'business' has resulted in the profession being best placed to respond to such demands. Firstly nurses are easily the most numerous of the healthcare professions with some 47000 qualified mental health nurses alone in the UK in 2004 (DH, 2005), and are obviously then the largest available resource. Secondly, and perhaps more importantly, returning to the issue of the growing influence of service user (i.e. patient) choice and preferences, these groups have been shown to identify strongly with the advanced interpersonal qualities which nurses bring to their practice (Luker et al, 1998) with over half the respondents indicating a preference to be seen by a nurse rather than a doctor.

Given also that despite custom and practice there are in fact very few actual statutory or legal barriers to nurses expanding their roles (Masterson, 2002), then the force for change and expansion of the nurses' role becomes irresistible.

In 1992 the United Kingdom Central Council for Nursing, Midwifery and Health Visiting published the Scope of Professional Practice report or 'Scope' (UKCC 1992). This was in essence an enabling document, which allowed nurses to take on new roles and activities where a clinical need could be established, providing such activities could be considered as being underpinned by the boundaries of nurse education, theory and knowledge. Such boundaries are however increasingly recognized as being dynamic (Briggs, 1997), placing the nursing profession in a unique position to expand its role and increase its autonomy (Pickersgill, 1993).

One of the key changes which Scope introduced was the removal of the need for post registration certification to legitimise any extended practice, a requirement which had previously served as an obstacle or limitation on the development of the nurses' role. Instead, responsibility was given to individual nurses to ensure that their knowledge and skills base was sufficient for the required task or role and that all practice was conducted within a specified code of conduct. Effectively then, Scope was a response by the nursing profession to the external demands being placed on it at the time, removing obstacles to and providing a framework for expansion of role.

It is in the context described above therefore, that this study is located, with nurses undergoing training in clinical practices more traditionally associated, often even by the nurses themselves with other professions such as clinical psychologists or psychiatrists. The bulk of the literature pertaining to the impact of this brave new world where nurses are free to develop their practice with minimal restraint relates to general nursing, nurse prescribing and the carrying out of specialist physical procedures (Magennis, 1999). There is very little in the existing literature regarding mental health nurses extending into the role of delivering psychological therapies and here is perhaps where this study hopes to makes a significant contribution to the literature.

1.4.5: The history and experiences of nurses training to deliver psychological interventions

1.4.5.1: Introduction

In this study the research participants belong to professions, mainly nursing and occupational therapy, who traditionally have a broad clinical remit, which may or may not according to individual circumstance, include the delivery of psychological therapies to their client/patient groups.

In this section the reader is introduced to the existing studies which examine the process of training nurses to deliver psychological interventions such as CBT across a variety of settings. Whilst the main focus will be on nurses and CBT, because of a relative paucity of literature specifically on this topic, it is also prudent to adopt a wider perspective and consider the training experiences of non-nursing healthcare professionals as well as studies which relate to training in psychological interventions other than CBT where relevant and appropriate. The key theme in the studies reviewed in this section is that they examine broadly similar circumstances to those which exist in this study, namely the training in psychological interventions for professional groups for whom prior to the post registration training this is either usually only a small part of a far wider professional remit or on occasion not part of their usual work practice at all.

1.4.5.2: The history of nurses as therapists

The history of nurses training in psychological therapies dates back to 1972 and the first English National Board (ENB) behavioural therapy (BT) course, the 18 month ENB 650 course held at the Maudsley Hospital, London producing the first truly autonomous nurse practitioners in the UK. By 1992 a further three training sites had joined the Maudsley and a total of 187 nurses had successfully completed the training (Newell & Gourney, 1994). Newell and Gourney's study noted that these nurses tended to be educated to degree standard (this was a time before graduate nurses were commonplace) with many going on to attain masters/doctorate level degrees and most undertaking further formal clinical training, confirming long-held suspicions that these nurses who had trained in BT were part of a self-selecting *elite* amongst the profession. Although the real-life distinctions between the practice of cognitive therapy, cognitive behavioural

therapy and behavioural therapy can become somewhat muddied, it is worth emphasising that these early courses, particularly the original Maudsley course were very strongly behaviourist in orientation at the expense of the more cognitive interventions. The next push to equip nurses to deliver psychological therapies came with the recognition that psychosocial interventions had a great deal to offer to patients suffering from psychotic disorders, such as schizophrenia, and their families (Barrowclough & Tarrier, 1984). Although the role of community psychiatric nurses with this patient group had tended to diminish with the increasing location of these nurses in primary care (Brooker, 1987) and what contact they did have tending towards administration of depot antipsychotics medication (Wooff et al, 1988), the increasing evidence base for CBT as an effective treatment for symptoms of schizophrenia (Dickerson, 2000) and the proliferation of such training opportunities as the Thorn initiative led to a renaissance of nurses training in and delivering psychological/psychosocial interventions to this patient group.

1.4.5.3: Summary of the findings from existing studies

It was quickly established, even through follow-up of that very first ENB course that the psychological interventions delivered by these nurses was both clinically effective and cost-effective (Ginsberg & Marks, 1977). Brooker (1992) demonstrated the positive effects of psychosocial interventions delivered by suitably trained nurses for both sufferers from schizophrenia and their carers. Milne (2000) looked more closely at these claims of effectiveness for short courses training mainly nurses to deliver psychological interventions whilst in the same paper advocating a more thorough and systematic approach to evaluating his own brief, 8 days in duration, training workshops. He highlighted that many existing studies had traditionally relied too heavily on self-report measures, omitted baseline measurements of skills before training, neglected to assess the impact of the training upon the patients and also drew attention to the tendency for such courses to have a diminishing impact on the trainees' behaviour with increasing time with limited generalisation of the training despite positive learner satisfaction measures. The problem of poor generalization from the training environment to the clinical domain was further

highlighted by Corrigan et al (1992) building on the earlier work of Emerson & Emerson (1987) by identifying and analysing those factors or barriers which staff felt would prevent increased utilisation of behavioural strategies. In the most recent study of its kind, Ryan et al (2005) took a longitudinal survey of nurses graduating from a year long training course in behaviour therapy over a 13 year period. The findings from this study showed again that whilst satisfaction with the teaching was very high only 17% of total graduates surveyed described BT as the main focus of their current work with 33% stating that they frequently used BT *skills* since completion of the course. Ryan et al (2005) concluded that although job movement since finishing the course accounted for part of these findings it did raise the issue of how much opportunity the course graduates had in their work situations to utilize their skills. In a study in which the training if not the research focus feels possibly closest in spirit to my own, McCann & Bowers (2005) describe their experiences in trying to deliver CBT for psychosis training to both qualified and unqualified nursing staff on acute psychiatric wards. The training appeared to have been relatively short-term, although strangely the study does not give the exact duration, and was non-award bearing in nature. The trainees were a mixture of nursing grades and appeared to have attended the sessions of groups of between 5 and 11 members. The providers of the training in effect had to 'sell' the idea to both staff and their managers and attempt to engage them in the project. The training was made flexible in terms of where, usually in-situ, and when it was delivered in order to maximise the potential for staff attendance. Unfortunately most of the findings from this study were either in the form of a reflective journal, which the researcher kept, or in the form of responses to simple agree/disagree questionnaires completed by the attendees, and so an opportunity to gain richer more in-depth qualitative data was perhaps lost. The study suggests however that inadequate management and poor staffing levels were key determinants of the likely success or failure of any such enterprise, very much confirming the findings of Emerson & Emerson (1987) and (Corrigan (1992) as described above. Tarrier et al (1999) reviewed most of the formal training initiatives in psychosocial interventions in this country up to that date, concluding that, as was stated in the *a priori* literature review for this dissertation, more research is required into both the factors which influence the

successful dissemination of psychosocial treatments, as well as the actual methodologies which are used to evaluate it. They conclude by suggesting that there is also a requirement to reassess the goals of training in psychosocial interventions, explaining that we have not yet sufficiently defined either the level of skills which training/dissemination might make available to the workforce nor what exactly our expectations of these trainees is in terms of performance.

1.4.5.4: Alternative perspectives

Other studies have focussed on different groups of healthcare professionals and attempts to train them to deliver CBT or, again have focussed on nurses but examining attempts to train them in different psychotherapeutic treatment modalities.

In a study of Australian case managers in a rural setting comprising a combination of those with both social work and psychiatric nursing backgrounds, Donoghue et al (2004) offered the participants 10 one day workshops in CBT skills. In a qualitative evaluation of the program many of the same themes which have emerged from this study are duplicated. All participants found the training useful. Some expressed the view that the complex presentations and likely resistance of clients made the skills difficult to translate into practice. There was a general feeling of being more comfortable with CBT but anxieties concerning competence to practice and general confidence issues were commonplace, with a complaint of limited opportunities to practice the taught skills. The case managers also cited workload issues and inadequate support from management as barriers to implementation of these skills.

In a randomised trial of CBT delivered by social workers to depressed adolescents, Kerfoot et al (2004. p.92) found that training community-based social workers in CBT was "*neither practical nor effective*" in improving the outcomes of clients using quantitative measurements. The training course in this instance comprised one full day and four half days teaching with fortnightly supervision being offered for which attendance was noted to be "patchy". Although the researchers admitted that the sample size may have simply been to

small to detect a positive effect, they suggested that the demands made on front-line staff who often have conflicting priorities makes planning and preparation for the application new skills very difficult and that "*problems can arise in training professionals from one discipline in the skills of another*" (Kerfoot et al p.98).

Other studies have instead focussed on nurses training in therapies other than those in the cognitive-behavioural realm. Paley et al reported on a training initiative where four mental health nurses were trained to deliver the conversational model of psychotherapy. The researchers caution that development of good quality evidence-based practice does not come cheap and that investment and support from senior management is vital and therefore has major resource implications. Most tellingly they state: "*the initiative has been included within the Trust specialist psychotherapy service clinical governance and audit committees. This was implemented to ensure that the initiative has 'a home' within the Trust and is embedded within other Trust strategies rather than being a project developed in isolation that could easily wither*" (Paley et al 2003, p.497).

A good overview of the kinds of problems faced when nurses (and other professions) attempt to apply newly taught clinical skills in their routine work environments is found in Fadden (1997). Fadden reported on the experiences of a group consisting predominantly of nursing staff training in behavioural family therapies. Fadden highlighted 32 areas that might affect the ease with which the therapy might be implemented. The four most commonly reported problem areas in decreasing order of statistical significance were: availability of appropriate clients, integration with existing responsibilities, engagement with clients or families and allowance of time from the service to do the intervention. Lack of knowledge featured at seventh on the list and lack of confidence at nineteenth. Because of these reported difficulties and the fact that the mean number of families seen by each of the 59 therapists who completed the survey was a mere 1.7, Fadden (1997, p.610) concludes (essentially echoing Paley et al 1993 as described above) that if change in clinical practice is to be achieved then there must be corresponding changes in the work systems to allow such changes and that the responsibility must be corporate rather than individual, and cautioned that "*there is a danger that large amounts of money will be spent on*

training programmes without sufficient attention being paid to overcoming obstacles to their implementation".

1.4.6: The Cognitive-Behavioural Model/Cognitive-Behavioural Therapy

This final section of the a priori literature review introduces the reader to both the cognitive behavioural model as well as to cognitive behavioural therapy.
The cognitive-behavioural model is central to this study in two distinct ways. Firstly, cognitive-behavioural therapy which is a clinical application of the model, is the therapeutic intervention which is being taught to the research participants whose experiences of trying to apply the model in their clinical practice is the main focus of this study. Secondly, the cognitive-behavioural model will be used to conceptualise the two key processes to emerge from the grounded theory analysis of the data. It is important therefore to orientate the reader to both the theoretical basis and practical application of the therapy which the research participants are being trained in as well as providing an account of the terms of reference i.e. the CBT model, used to conceptualise the research participants' experiences, which is presented later in the thesis.
Accordingly, in this section the underlying theory of the cognitive-behavioural model of psychology is described, as well as a providing a brief account of the history of its development. A justification is also provided for the use of the cognitive-behavioural model within the overall qualitative methodological context of this study. This section also provides a description of cognitive-behavioural therapy, the scientific principles which underpin its use, how it is delivered and its most common applications in clinical practice.

1.4.6.1: The cognitive-behavioural model

The cognitive-behavioural model is an amalgam of two different schools of psychology: cognitive psychology and behaviourism.
Cognitive psychology is the school which concerns itself with the individuals internal mental processes which mediate between stimulus and response. It encompasses the diverse fields of memory, reasoning, problem solving and language. Cognitive psychology can legitimately be thought of as occupying the

middle ground between the psychodynamic and the behavioural schools of psychology. In common with the psychodynamic theories of the mind it accepts that internal, not directly observable factors such as motivation are a legitimate focus for study. In contrast however, it rejects introspection or interpretation as a valid method of analysis and in common with behaviourism fully embraces the scientific method of investigation. Jean Piaget, in studying children, was one of the earliest and most prominent psychologists to give prominence to the way in which the human mind makes sense of its surroundings. Broadbent (1958) was the first to articulate and describe an information processing model of cognitive function broadly analogous to what we would recognise today as software run on computers. The cognitive *psychotherapies* which emerged in the 1960's most notably George Kelly's personal construct theory (Kelly, 1955), Albert Ellis the founder of rational-emotive therapy (Ellis & Harper, 1975) and Aaron Beck with cognitive therapy (Beck, 1967) effectively mirrored this focus on how internal mental structures mediate between an individual and his/her environment as well as continuing to stress the importance of scientific rigour in the approach.

Behaviourism was the consequence of a revolt against the prevalent psychodynamic school of psychology in the early 20th century. Sigmund Freud, the most famous proponent of the psychodynamic school, espoused the key roles which unconscious mental drives or processes, regulated, or otherwise, by conceptual psychic structures played in the manifestation of the individual's behaviour (Freud, 1923). Behaviourism's central tenet however, was that only that which is observable and quantifiable i.e. behaviour, is a valid focus for study. John B. Watson (1930) insisted that since the mind could not be observed then to have mental processes or supposed unconscious forces as a focus for study was profoundly unscientific and therefore invalid. Watson (1930) and later Skinner (1984) viewed learning as the basis for all behaviour and gave rise to the now familiar concept of conditioning. Behavioural *psychotherapies* most notably developed through the work of Joseph Wolpe (1958), who showed how fears and phobias could be learned, reinforced and then unlearned all through the influence of conditioning and desensitisation, and with Burchard & Barrera (1972) who pioneered the system of token economy whereby rewards were given in an institutional setting to reward desired behaviours whilst undesired

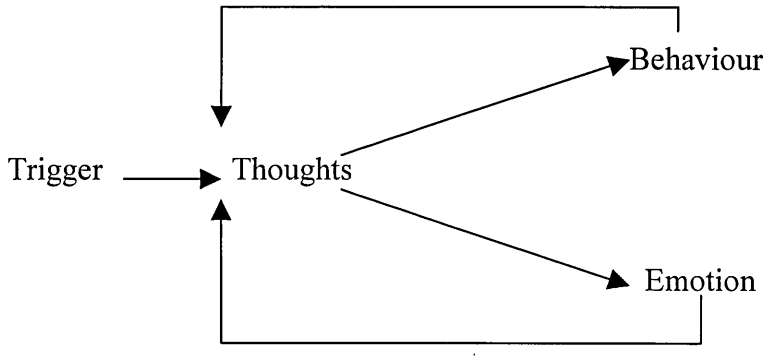
behaviours were left unreinforced, effectively finding a practical application for Skinner's earlier work on operant conditioning.

The cognitive-behavioural model effectively married these two schools, Meichenbaum (1977) with his work: '*Cognitive-Behavior Modification: An Integrative Approach'* perhaps being the most notable. Although there is not one single cognitive-behavioural approach, most approaches which term themselves cognitive-behavioural have the following commonalities:

- The key role of self-dialogue or inner speech
- The notion of self control or self regulation through conscious access to and modification of internal thought processes
- The usefulness of self-report
- The interrelationship between thoughts feelings and behaviour
- Cognitive mechanisms as a mediator between environmental events and their emotional/behavioural consequences
- The centrality of learning theory

Most cognitive behavioural theories are also based on the concept of a causal relationship between thought, emotion and behaviour represented below by figure 3.

Figure 1. A Simplified cognitive-behavioural model



It is useful to point out at this stage that although the cognitive-behavioural model is most frequently used to describe psychopathology or emotional

disorder, it is also equally valid in describing 'normal', non-pathological human behaviour, hence its utility as a way of conceptualising the experiences of the research participants in this study. Much of the literature for example on stress management in the workplace (Palmer, 1994; Neenan & Palmer, 1996) has utilised both a cognitive behavioural conception of both stress related problems in the workplace and the potential solutions to these problems. In a broad sense, the challenge of learning then applying a newly learned skill which is perhaps not core to that individual's professional identity can also be considered 'a stressful situation' in the workplace and therefore Neenan and Palmer's work cited above can be considered to be a precedent for the use of a cognitive-behavioural conceptualisation in this study.

It has already been established that a constructivist paradigm is employed in this study. I would assert that the use of a cognitive-behavioural conceptualisation of the research participants' experiences in this study is entirely consistent with that philosophy of approach. In the British Association for Behavioural and Cognitive Psychotherapy's (2005) explanatory leaflet "What are Cognitive and/or Behavioural Psychotherapies?" the cognitive component in the cognitive-behavioural psychotherapies is described as referring to "*how people think about and create meaning about situations, symptoms and events in their lives and develop beliefs about themselves, others and the world*". This has obvious and immediate parallels with the constructivist epistemological paradigm, namely that knowledge does not reflect any absolute knowable reality but instead is constructed largely through the ways in which individuals and groups perceive and experience their social relationships and interactions. Therefore, in both the cognitive-behavioural model as well as the constructivist epistemological paradigm, the *meaning* which individuals ascribe to their social situations and experiences is the key facet of the overall research situation to be discovered and understood.

1.4.6.2: Cognitive-Behavioural Therapy

Cognitive-behavioural therapy (CBT) is the therapeutic intervention which was taught to the research participants in this study. It is necessary therefore to provide a brief outline of the underlying rational for the therapy, how it is

delivered and which psychological conditions it has proven efficacy for, and therefore the clinical needs which it is most frequently employed to meet.
The underlying rational for CBT is in essence the same as that for the cognitive behavioural model as described above. Its core psychological tenet is that it is the individual's distorted or biased perception of triggering events, the meaning which he or she attributes to a situation which is the cause of emotional distress. This distorted perception then leads to emotional or affective changes and also to problematic excesses or deficits of behaviour which further reinforce the problem. The following short vignette provides a real life illustration:

Allan suffers from a depressive illness and has low self-esteem. Recently a friend walked past him on the street and did not acknowledge his greeting. He interpreted this as an indication that the man he believed had been his friend no longer liked him and had actively tried to avoid him. This caused Allan to feel deeply unhappy, ashamed and worried about how he was viewed by his other acquaintances. Because he anticipated having his concerns confirmed through future social contact i.e. that nobody liked him, he altered his behaviour by avoiding social contact in general and in particular with the friend who had not acknowledged his greeting. Because of his avoidant behaviour his activity levels and social contact grew less, he was unable to discover any evidence, which might have countered his negative beliefs about how others saw him and his depression worsened.

Therapy therefore involves encouraging the individual to first identify and then to challenge their negative beliefs by either a process of logical reasoning called Socratic questioning and/or behavioural experiments designed to put the individuals negative predictions to the test. In Allan's case he might be encouraged to renew contact with his friends and even ask the friend who he believed ignored him, his recollection of that day in order that he might obtain evidence which would disconfirm his negative beliefs. Previous learning, influenced by distortions of thought, selective attention to the negatives and the influence of maintaining behaviours typically excesses or deficits such as avoidance or over-compensation create and reinforce problematic beliefs in the patient. The goal of therapy is to allow the patient to re-learn a less negative,

less catastrophic way of understanding themselves and their situation. A key concept in CBT which has been borrowed from cognitive psychology, is that of the *schema*. In CBT the schema is a relatively stable, long-lasting psychological construct which allows the individual to process new information according to a template of belief. These schemata can be an important contributory factor to a patient's problems for example, *If I am less than perfect I am a failure*, if *there is a problem it is my responsibility to resolve it* or *uncomfortable feelings are intolerable and must be avoided.* Each of these schemata represents a rule or belief, which is overly rigid and almost impossible to achieve with any consistency thus inevitably adding to a patient's psychological distress. Identifying and then moderating these schemata then becomes an important goal for therapy.

CBT is not however simply the straightforward application of cognitive – behavioural principles dressed up as a bona fide therapy. Of equal importance to the underlying scientific principles is the *style* of delivery. CBT is a collaborative therapy which requires that the patient take equal responsibility with the therapist for all aspects of the therapy from helping with assessment of the problem situation, for example through diary work, to making the necessary changes to the maintaining behaviours in order that re-learning might occur. The role of the therapist is not to tell the patient what to do or to solve a patient's problems for him/her, rather it is to aid the patient in learning about and discovering solutions to his/her own problems through mutual discovery. The therapy is time limited, has a focus on quantifiable, observable problems which occur in the present and can only be effective if the patient desires to be in therapy, accepts a psychological formulation of his/her problems and is willing to contemplate change. CBT is not something which therapists can ***do to*** their patients.

CBT was initially found to have proven efficacy for mild to moderate clinical depression (Blackburn et al, 1981). There was then considerable research into the application of the CBT approach for the anxiety disorders such as panic disorder, agoraphobia and obsessive-compulsive disorder, where again a solid evidence base for its efficacy was established (Barrowclough et al, 2001). In more recent years CBT has been found to be effective for other psychological disorders such as symptom reduction in psychosis (Durham et al, 2003), bulimia

nervosa (Ricca et al, 2000) and medically unexplained symptoms (Nezu et al, 2001). Broadly speaking however, the practice of CBT outwith specialist centres and research trials tends to continue to focus on the treatment of the anxiety disorders and depression.

Chapter 2: Research design

2.1: Introduction to the chapter

This chapter will describe the considerations which were made in selecting a research design appropriate to answering the stated research questions for this study.

Specifically, the inclusion of the grounded theory methodology used within this study will be justified and its consistency with the stated epistemological and ontological positions adopted for this study will be established. Similarly, it is necessary to justify the inclusion of an action research design within this study, review the use of the action research methodology within the fields of education and healthcare and define which form of action research is used within this study.

Because two distinct methodologies are being utilised in tandem in this study, this chapter will review the function and legitimacy of employing these two methodologies (namely action research and grounded theory) and explore any potential inconsistencies inherent in this combination.

This chapter will also review the subject of ethics, in particular its relationship and relevance to qualitative research as well as describing and justifying the underlying ethical approach which was used to guide the conduct of this study. The concept of reflexivity and its utility as a tool within this study will also be considered in this chapter.

2.2: The choice of research design

Mason (1996) suggests five "difficult" questions which might guide the researcher in considering the essence of a research question or enquiry and thus how a study might be designed. Whilst it would be an overstatement to say that these questions directly shaped my research design, I did use them to guide and influence the shape that my design took as I planned for this study.

The first of these questions is: "What is the nature of the phenomena, or entities, or social 'reality', which I wish to investigate?" Given that I found myself at the

intersections of both nursing/teaching roles as well as of nursing/cognitive therapist roles, then it seemed logical to explore this blurring of identities. I was subjectively aware that whilst many students had attended the CBT training workshops which I had provided, there was a wide range of training outcomes including those who did not go on to use the training in their clinical work, those who did with great zest and others who showed initial interest but then never made the transition from the classroom to the clinical area. For reasons discussed earlier in this chapter I had clearly identified a *personal* ontological position whereby the practice of CBT not only was harmonious with my existing identity as a psychiatric nurse but also, I felt enhanced it. The phenomenon which I therefore wished to investigate became the alternative ontological positions of my students, how their social realities differed from my own in the key areas of identity (and inevitably borrowing from the CBT model) attitudes, beliefs, thoughts and emotions.

Mason's second question: "What might represent knowledge or evidence of the entities or social 'reality' which I wish to investigate?" refers to the central epistemological question i.e. how can a researcher legitimately claim to know the social phenomenon which he or she has chosen to study? This inevitably will have a major influence on the choice of any subsequent research methodology. Given that it has already been decided that the study would be both qualitative and a case study of in effect a single situation, then it is necessary to reject the positivist notion that there is a single, universal social reality to be discovered or that the research subjects will somehow behave according to some general law, and instead embrace the interpretivist/constructivist standpoint that the social reality to be researched will be constructed through the meanings and interpretations of the research participants as well as the researcher.

In this study, the idiographic approach to knowledge, as described first by the Neo-Kantian philosopher Wilhelm Windelband (1894) is therefore favoured over the nomothetic. Knowledge in effect becomes the meaning or interpretation the research participants ascribe to their particular situation.

Mason's third question: "What topic or broad substantive area, is the research concerned with?" must logically follow-on from the ontological and epistemological positions outlined above. My own ontological position is that

the research participants will ascribe different meaning to CBT training compared to myself. They will have a sense of professional identity composed of beliefs, attitudes and thoughts which will in turn influence and be influenced by the CBT training and ultimately account for (at least in part) any transfer of training from the classroom to the clinical area. My epistemological position is that these particular dimensions of the social world are knowable through utilization of a constructivist methodology. The broad substantive area under study therefore becomes the research subjects' sense of identity and what part it plays in the process of training transfer.

The fourth question in Mason's list asks: "What is the intellectual puzzle? What do I wish to explain? What are my research questions?". The research questions have already been stated earlier in this thesis but it is fair to say that the "intellectual puzzle" which the research questions should be attempting to explain has not yet been clearly articulated. An area for research has been proposed, but what is the mystery within that area? What requires generation of theory to aid understanding? I have already described a subjective awareness that learners react differently to similar CBT training, some carrying it forward into their clinical areas and some not, despite them operating in broadly similar environments. The puzzle therefore becomes a division of the *what*, the *why and the how: What* are the influences in terms of professional identity and meaning ascribed to the CBT training which cause this variation of outcome? *Why* are they different from person to person and *how* do they influence the process of training transfer?

The final question in Mason's list asks simply "*what is the purpose of my research? What am I doing it for?*" This question is relatively simple to answer. There is little empirical evidence to link educational input for health professionals with change in practice and hence improved patient outcomes. (Jordan, 2000). CBT has been established as effective evidence based treatment for some of the most common psychiatric disorders. Continuing professional development for health care professionals is now largely compulsory. It is also expensive and time consuming. If therefore there can be some explanation or theory generated to explain why despite its established benefits and apparent appeal, not all CBT training results in CBT practice, then the potential would exist to make more efficient use of resources, to potentially better match

learners with courses and to refine the training to address any internal obstacles to change. The research therefore can serve the purpose of generating understanding in a poorly researched and understood area with very genuine potential financial and ultimately health/well-being benefits. Whilst it would be absurd to make any grand claims that this small case study can provide any great generalisable theory, Jordan (2000) nevertheless makes a convincing argument that case studies and small scale 'teacher-researcher' projects can produce inferences with greater theoretical sensitivity and clinical relevance than those derived from statistical techniques alone and that by bringing insight and sensitivity into the field, are in a unique position to originate theory.

2.3: Grounded Theory

It has already been established that this study is exploratory in nature. The goal is to discover what is happening in the interface between learning and practice and to theorise how the learners' constructions of their own social realities might influence this. The aim is to explain how these internal realities might alternatively help or hinder the process of training transfer. Qualitative research however is not a single or unified approach it is according to Denzin & Lincoln (1994: ix)" d*efined primarily by a series of essential tensions, contradictions and hesitations*".

The selection therefore of grounded theory, as opposed to any other qualitative methodologies, as the main methodology for the study has to be consistent with the aforementioned ontological and epistemological standpoints as well as the nature of the research questions the study intends to answer. There has however an ongoing and at times polemic debate being waged in the literature between the co-originator of the grounded theory approach Barney Glaser and his one time research partner Anslem Strauss with the fundamental difference of opinion centring on the relationship between data and theory. (Glaser, 1992). I therefore consider declaring myself simply to be following a grounded theory approach would be an insufficient description of my research methodology/epistemological position, given that Glaser himself effectively considers Strauss' later works (Strauss & Corbin, 1990) to have delineated so

far from the original conception (Glaser & Strauss, 1967) that it can no longer lay claim to the appellation 'Grounded Theory'.

Grounded theory has attracted various criticisms from qualitative researchers belonging to alternative traditions such as ethnography and phenomenology since its inception in 1967 (Crano & Brewer, 1986; Thorne, 1991). I would assert however that the ongoing debate within the grounded theory community in fact represents an internal attempt to either clarify the contradictions and ambiguities inherent in grounded theory, which have attracted said criticisms or in certain cases redefine the theory itself. Due to its somewhat paradoxical nature, grounded theory has at its core an identity crisis which renders it vulnerable to attack from several quarters: Accusations of positivism have been levelled by those qualitative researchers coming from an strictly naturalist/relativist viewpoint highlighting grounded theory's rigorous systematic, approach and prescriptive instructions on analysis which of course lends grounded theory its alleged 'scientific credibility'. The constructivists have suggested that grounded theory's emphasis on unforced emergence and the researchers adoption of a Tabula Rasa approach to prior knowledge implies that grounded theory covertly embraces a critical realist philosophy i.e. "the truth is out there" (Annells, 1996). That aforementioned "Tabula Rasa" approach also attracts a great deal of criticism in itself. Crano and Brewer (1986) suggest that the "experimenter expectancy effect" will inevitably introduce a source of bias into observation and therefore coding, in effect echoing the familiar accusations of naive inductionism which grounded theory has attracted over the years (Haig, 1995). Naïve inductionism is essentially the belief that researchers can and should maintain a value neutral stance in both their observations and their analyses, not allowing logically deducted prior hypothesis to influence proceedings but at the same time being sufficiently steeped in the literature to be able to recognise what a theory is (Glaser, 1978). This is a stance which many now consider to both unrealistic and unhelpful in that it can lead to inward looking, sterile studies. Critics have also attacked grounded theory's focus on theory generation, Crano & Brewer (1986) pointing out the inadequate provisions for verification, an issue which both Glaser and Strauss have significantly differing opinions on, Glaser believing that verification lies out with the remit of grounded theory whilst Strauss and Corbin's frequently refer

to the need for validation and verification throughout the course of a research project (Strauss & Corbin, 1994).

In effect then, grounded theory can be described as both unforced and reliant on emergence but also systematic and rigorous with complex rules and strategies to guide analysis. Verification is alternately a key aspect of the research process and also "*exactly what we had tried to get away from*" (Glaser & Strauss, 1967 p. 67). It has strong scientific credentials yet it is a qualitative methodology using an inductive (non logico-positivist) method of theory generation, which has been widely adopted by researchers interpretive or naturalistic approached to their subject matter.

These apparent contradictions and ambivalences are perhaps central to the split between Glaser and Strauss who have demonstrated a fundamental disagreement on the relationship between data and theory. I believe that if one traces a path through this disagreement then credible rebuttals to these external criticisms present themselves either through clarification of the original philosophy of approach or through its subsequent refinement:

Glaser (1992) argues that subsequent developments of the original method (Strauss & Corbin, 1990; Charmaz, 1994) "forces" the emergence of theory from the data by using a preconceived framework which Glaser believes can create the potential for the researcher to miss the true relevance of the data. Glaser advocates the adoption of an unforced inductivist approach, allowing the theory to emerge more naturally from the data. Both researchers claim to reject naïve inductionism. Glaser posits his concept of "coding families" (Glaser, 1978) as a means of maintaining the required theoretical sensitivity whilst protecting the emergent theory from contamination by the researchers extant theoretical sensitisation. The 'Straussian' camp e.g. Charmaz (1994) adopt a more interpretivist, even pragmatic position suggesting that all theory is essentially provisional and is constructed actively between the researcher and his /her research participants. Given the nature of their aforementioned stated beliefs on the relationship between data and theory, the two camps adopt predictable stances on the subject of prior knowledge and the literature review. Glaser is of the opinion that the researcher should enter the research setting with as few pre-determined views or prior hypotheses as possible even going so far as to suggest that the research problem itself is only discovered once the process

of open coding has begun, suggesting that the researcher begins his or her study "*with the abstract wonderment of what is going on that is an issue and how it is handled*" (1992, p.22). The Strauss/Corbin/Charmaz camp adopt a more pragmatic view, namely that researchers' "guiding interests and disciplinary perspectives should provide grounded theorists with such points of departure for developing, rather than limiting their ideas" (Charmaz, 2000), and that "*all kinds of literature can be used before a research study is begun ...*" (Strauss & Corbin, 1990, p.56). Differences also exist between the two camps opinions on the purpose and parameters of the true grounded theory approach. Glaser strongly criticises Strauss for his constant emphasis on theory verification believing that grounded theory should instead be directed at the discovery of theory or hypothesis with verification being something which they were actively trying to get away from with their early work on grounded theory. Strauss on the other hand argues that verification can and should be established through judgments about reliability, validity, generalisability as well as the quality of the coding process.

My own stance is that if not the actual Glaser/Strauss split, then some profound schism within the grounded theory community was inevitable. Grounded theory has I believe, at its core, a series of fundamental paradoxes and contradictions. Firstly it is a method of generating theory through a *systematic* set of procedures, which accords it its scientific credentials, but it is also a useful method of analysing qualitative data based on an essentially *subjective* process of interpretation through coding and induction. Glaser accuses the Straussian camp of leaning dangerously towards a positivist philosophy due to insistence on sound scientific principles of reliability etc as well as allowing over-elaborate methodologies to contaminate theory, whereas the Strauss et al argue that Glaser's insistence on rigid inductivism with strictly limited influence of prior knowledge on early coding operations to be both impractical and also with the potential to result in "sterile" or "boring" studies (Strauss & Corbin, 1994 p.166) which discount potentially valuable insights which the researcher has to bring to the work. The question of prior knowledge and use of extant theories to guide the coding process has never been satisfactorily resolved and can in fact appear contradictory. In the original 1967 work Strauss and Glaser accept that "*the researcher does not approach reality as a tabula rasa*" and coin the term

"theoretical sensitivity" to describe the necessary qualities which the researcher must have in order to extract meaning from his or her data but the book remains vague on how exactly prior knowledge might be developed into theoretical sensitivity and how that should be applied without forcing the analysis. Kelle (2005) makes the observation "one gets the impression that a grounded theorist is advised to introduce suitable theoretical concepts *ad hoc* drawing on implicit theoretical knowledge but should abstain from approaching the empirical data with *ex ante* formulated hypotheses" which is surely an impossible contradiction.

The position which I most closely identify with, and have therefore used whilst engaged in coding and categorisation operations during this study is broadly analogous with the Strauss and Corbin/Cathy Charmaz position. Urquhart (2002) however, argues convincingly for Madill's (2000) position that grounded theory is in essence a method, a method which can be used to analyse data independently of any philosophical position and it is this pragmatic approach which I have adopted in this study. As mentioned in a previous chapter, this research was initiated in order to gain a research degree. Accordingly a research proposal was required to be submitted to various academic institutions including specifics of the research proposal and research questions. As also stated earlier, the specific area of research, namely the influence and impact of professional identity on CBT training transfer was borne out of my observation of both my own personal experience and that of others I had taught. In accepting Glaser's position on allowing the research question to develop from the initial coding i.e. after the study has begun, and the use of extant theories to guide analysis then I find myself effectively disqualified from claiming allegiance with his stance. I would go so far as to suggest that it is hard to imagine any research student progressing far with his or her PhD proposal if they were to adhere to Glaser's position on the research question! My use of the CBT model later in this dissertation to provide a conceptualisation of the finished analysis also makes it abundantly clear what my position on the use of extant theories is. Both camps claim to reject 'naïve inductionism', Glaser through the adoption of 'coding families' whereas Strauss, Corbin and Charmaz adopt a more realistic balanced approach making the perfectly reasonable suggestion that a researcher's prior knowledge might actually be advantageous in extracting meaning from data

(Charmaz, 1994). If I was to adhere to Glaser's position for this research then I would have to in effect set aside my years of being taught, teaching and practising CBT as well as somehow ignoring the insights I have gained as a consequence of setting out on a similar journey to that of my research participants. Not only would this be too great a sacrifice of potentially valuable sensitising information for the advantage of some specious notion of 'unforced emergence', but also I seriously doubt, given my closeness to the research subject whether I could ever legitimately claim to be able to adopt an *outsider stance*. Another reason I have adopted the methodology advocated by Strauss et al is again due to the pragmatics of being a novice researcher. Having permission to utilise my prior knowledge in the process of coding/categorisation allows me a sense of recognition and direction during the process whereby I can detect provisional meaning and relatedness in the data. "Abstract wonderment', the frame of mind Glaser advocates researchers adopt during initial coding (Glaser 1992 p.22), may perhaps paradoxically, be an easier mindset for the experienced researcher to achieve. My position on verification must be explicit given its importance in determining the validity of any claims I make regarding the stated aims, scope and limitations of this study. Broadly speaking, Strauss et al believe that verification can and should be part of grounded theory analysis and achieved by within analysis hypothesis testing, a position which Glaser vehemently rejects believing that grounded theory is about generating theory/hypothesis and that verification is the domain of natural science subsequent to development of a grounded theory. On the one hand the Strauss & Corbin claims re the verifiability of their approach, and its adherence to 'the canons of good science' are enormously appealing. On the other, this study, as already described, makes extensive use of extant knowledge. I am very close to my subject matter. Constant comparison of data, codes, categories, developing theory and prior theories, particularly given that I am the sole researcher on this project, could legitimately render any claims of verifiability justifiably open to accusations of excessive insularity. I would instead agree with Glaser's stance that *validation* through method is perhaps a more realistic goal and quality benchmark of a grounded theory study, leaving verification for another time. My own stance is therefore that this study does not make claims to have verified itself and therefore I would describe the strength of this study and therefore the

strength of grounded theory as being in its "*open-ended discovery orientation*" (Rennie, 1998, p.114) rather than claiming to somehow have both generated and verified my own theory.

I will close this section by offering a metaphor, which I believe portrays the delicate balance which must be achieved in grounded theory between emergence and constructivism. In my clinical work as a CBT therapist, typically I will initially encounter a large amount of essentially unstructured, mainly verbal, information from the patient and spend time listening, asking questions and sketching possible written formulations using a cognitive behavioural framework in an attempt to develop an understanding of the patients' difficulties in terms of key formative events, long-held core beliefs or schemata, negative automatic thoughts, maintaining behaviours and so forth. From this, a theory or explanation would emerge which I would then test out by reflecting it back to the patient, encouraging them to keep diaries etc in an attempt to verify, elaborate and refine the initial formulation. Most CBT therapists however will recognise a fundamental tension in this process balancing the need to keep an open mind using Rogerian, person-centred (Rogers, 1951) principles of respecting the patient and his or her problems as being unique, and therefore not forcing patients' problems into an artificially imposed pre-determined framework, but equally recognising the value and facility in being able to offer the patient a plausible and empowering explanation for what is frequently an incomprehensible array of emotional and psychological difficulties which in addition has a sound empirical evidence base for its effectiveness. This appears to me to be strikingly analogous to the competing tensions within grounded theory methodology, which we have just described above. Like those tensions within grounded theory, I believe it would be naïve to expect them ever to actually resolve into a simple 'right or wrong' categorisation. Instead I believe the best one can hope to achieve is to constantly be aware of and make explicit reference to those tensions in our work and adopt a pragmatic approach to the competing demands of philosophical preferences and the realities of any given situation, be it clinical or research.

2.4: Action research

2.4.1: Introduction

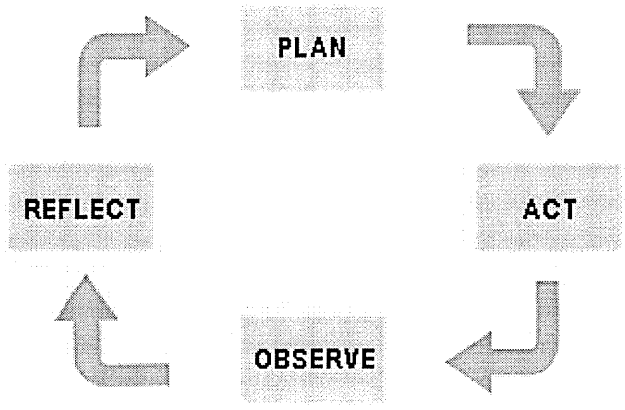
An action research approach was one of the two core methodologies employed in this study. This section shall expand on the brief summary of action research as a methodology given in the introduction to this thesis and review its application in the fields of education and healthcare, the overlap between the two being where this particular study is essentially located. Given however that there is no single definition of action research, which more accurately is a form of enquiry, encompassing a range of philosophies and approaches (McNiff et al, 1996), then it is important to go beyond the simple appellation 'action research' and describe in detail the specific characteristics of the approach as applied in this particular study. This section shall also examine how the action research component of this study might be located in and contrasted with existing action research studies in the fields of education and healthcare. Finally it is important to justify the inclusion of an action research methodology within the overall research design. The detail of how the action research cycle was actually implemented during the course of the study will be discussed in the *Methods* chapter of this thesis. The understandings and insights which can be drawn from this action research activity will be discussed in the appropriate section of the final *conclusions* chapter.

2.4.2: Overview

Perhaps the most succinct and globally applicable definition of action research is that offered by Carr & Kemmis (1986, p.162): "*Action research is simply a form of self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own practices, their understanding of these practices, and the situations in which the practices are carried out*". It can equally be used in both the positivist and the qualitative/relativist paradigms although in reality it is more common in the latter. Although McTaggert (1996) cautions against the reduction of action research to an easily replicated procedure or method, the four common stages of

action research: plan, act, observe and reflect are usually represented as a cycle (figure 2):

Figure 2: The Action Research Cycle



Action research has been closely associated with the field of social and community welfare particularly in the United States (Goetschius & Task, 1967) whilst in the United Kingdom there have been many prominent studies in the fields of education (Carr & Kemmis, 1986) and healthcare (Waterman et al, 2001).

2.4.3: Different philosophies of approach within action research

There are two main schools of action research which although sharing a common epistemology display significant differences in terms of a) the degree of respective politicisation of the two approaches b) whether the problem under examination is defined in terms of a social injustice to be remedied or a professional, usually teaching or educational, deficit where the goal is enhancement of direct practice, and finally c) is the undertaking primarily an individual effort by a lone researcher or is it a community endeavour where the participants share fully in the ownership of the problem and its solution?

The first school of action research evolved directly from the philosophy of the man generally credited with the coining the term 'Action Research' Kurt Lewin. Lewin (1948, p.203) observed problems of social injustice and inequality for which he felt "*research that produces nothing but books will not suffice*". This gave rise to a more explicitly politicised form of action research, most notably developed by Paolo Friere (1972) which has variously been termed: *community-*

based action research, *participatory* action research and even *radical* action research. Stringer (1999, p.9) described this form of action research as always being enacted through an explicit set of social values and having the core characteristics of being "*democratic, equitable, liberating and life enhancing*". In this form of action research, Bentz & Shapiro (1998) described the role of the researcher "*as a facilitator of a process of inquiry involving as many stakeholders in the situation as wish to be involved*" Using the term stakeholders to describe those people who the research problem directly impacts upon they go on to say: "*Ideally, these stakeholders will be involved in the research design, data gathering, data analysis, and implementation of action steps resulting from the research*". (p.128) In this context the action research movement can be seen as a part of the overall movement against the dominant scientific, positivist/objectivist paradigm of the early/mid 20th century. Using the terms *facilitator* and *stakeholder* in the above quote from Bentz and Shapiro also illustrates the concerns that researchers from this school had to avoid reflecting the traditional scientific/elitist power dichotomy of researcher/subject in their choice of terminologies.

The second broad school of action research, which Carr & Kemmis (1986) termed '*practical action research*' however adopted a more pragmatic philosophy of approach, less concerned with lofty aspirations of social justice and with less emphasis on the imperative for collective action. Partly at least, due to a reaction against its over-politicisation in the preceding decades, the fortunes of action research as a methodology declined in the 1960's. This second school which emerged largely from the works of British educational researchers, revitalised the field of action research retaining the centrality of the action research cycle, the primary goal of generating real-world solutions to improve a situation and the importance of ownership of a problem and the means of its resolution within a social grouping such as the teacher or nurse as researcher paradigm. There was however a de-emphasis of the socio-political rhetoric, the strict emphasis on community action and the location of any such endeavours within a broader context of power imbalance/quest for justice. Elliot (1991) suggests that action research rather than being driven by political imperative should instead be thought of as a moral undertaking, whereby the practioner be they nurse or teacher, applies his/her own moral values as the

prime motivator in the quest for improvement in their practice environment. A central tenet of Elliot's view of action research is that only those who have a direct stake in the research situation, those who have something of themselves invested in the problem can legitimately claim to have this moral connection to the research situation, thus strengthening the assertion that action research should be carried out from *within* (not by detached academics). This second school of action research, with its strong relevance to the work of Donald Schon and his concept of reflective practice (Schon, 1983) is the form of action research most likely to be encountered today particularly in the fields of education and healthcare where individual or small groups of researchers look to improve their practice through the action research cycle. It is important to stress here though that action research is not merely run of the mill 'thinking' which teachers routinely do about their teaching. Nor is it simply problem solving. Kemmis & McTaggert (1992) stress that the systematic and collaborative way that evidence is gathered distinguishes it from the former, whilst the way in which action research strives to improve practice by *posing* problems rather than simply identifying them and then learning how to improve the situation further by reflecting on the changes made sets it apart from the latter.

2.4.4: Action research in healthcare

In a comprehensive review of published healthcare action research studies in the UK since 1974, Waterman et al (2001) found a total of 59 studies, mostly from 1988 to 1996, which met their strict inclusion criteria for action research, predominantly qualitative in methodology, 70% of which were carried out by nurses, with observation, interview and questionnaire being the most common methods of data collection. Interestingly, the most common stated aim of the studies reviewed by Waterman et al was categorised as "*to improve the existing situation*" (2001 p.19) including clinical skills, the quality of life of patients and education. The development of knowledge was a stated aim of 27% of those studies. Not surprisingly perhaps, one of the most common stated reasons for choosing an action research methodology (69%) was (Waterman et al 2001, p.33) "*because it could potentially result in actual changes being made, as well*

as developing knowledge and understanding of the barriers or obstacles to change". The qualitative data collected in the study found that action research was valued for being "*flexible and responsive, and therefore suited dynamic, developmental and sensitive situations, particularly when more rapid responses or changes were required*".

In terms of the specific issues addressed by the healthcare action research projects, professional education and skills training was the most frequently cited (30%) with inappropriate or conflicting practices and professional roles also featuring strongly.

As a way of classifying the results of the healthcare action research studies, Waterman et al divided these into two distinct categories, outcomes and impacts. Outcomes could be either research, professional or educational outcomes with the most common being identification of problems. Impacts in contrast were defined as lasting effects or changes. Both these categories of result were viewed as having equal importance by the researchers.

2.4.5: Action research in education

Action research in education can be split into two schools broadly analogous to those mentioned earlier in this section. In 'Becoming Critical' Carr & Kemmis (1986) advocate *emancipatory* or *critical* action research in the field of education, very much drawing on the aforementioned traditions of Lewin originally and then most notably Friere whereby educational research is firmly rooted in social action, social change and group activism whilst simultaneously acknowledging and seeking to challenge existing power relations be they interpersonal or organizational.

The second school, which Kemmis (1993) describes as practical action research developed through the work of what became known as the 'teachers' action research movement" where the boundaries between teaching and research as well as teachers and researcher were abandoned and the two activities were viewed as being bound up in the same process. Stephen Corey (1953) was the first to advocate that teachers were best placed to research and improve their own practice rather than deferring to outside *experts*. Lawrence Stenhouse (1975) was the first British researcher to develop Corey's ideas further. He

retained some key concepts from the more radical socio-political form of action research, which had been popular in the United States, in particular his belief that action research in educational establishments should facilitate the emancipation of the student the teacher and the educational establishment: the student from the supposed paternalism of the teacher, the teacher from the educational establishment and the educational establishment itself from external political pressures. John Elliot (1978, 1991) argued that theory could in fact be validated through practice and that research was a fundamentally a self-reflective process whereby teachers examined their own theoretical basis for practice using their own autonomous professional judgments, whilst McNiff (1993) developed Elliot's key themes by arguing that educational knowledge is created by individual teachers as they attempt to express their own values in their professional lives.

2.4.6: Conclusions and justification for the use of action research within this study

Along with grounded theory, action research is the main methodological approach used within this study. It is important therefore to give consideration as to why an action research approach is considered to be consistent with both the subject matter and the stated research aims of the research, as well as the epistemological and ontological positions adopted in this study as described in the methodology chapter.

It has already been established that action research is a methodology widely adopted in the fields of education and healthcare research, which this study effectively intersects. This study essentially consists of myself, the author, researching my own teaching and the experiences of the learners in an effort to understand the barriers to training transfer specific to this situation and then through the application of the knowledge and understanding gained, improve that teaching and its relevance and benefit to those learners. This thesis can indeed legitimately be viewed as a direct reflection of the action research process: The research proposal and introductory chapters ***reflect*** on a problem area. The methodology chapter outlines and justifies a ***plan*** to gather more information. The teaching is the ***action*** which allows us to learn from practice

and the data contained in the results are a consequence of the ***observations*** or interviews which of course are once more ***reflected*** upon in the analysis and conclusions chapters. A cursory glance through the abstract and introductory chapter of this thesis will leave the reader in no doubt that this study adopts the second, less politicised form of action research described by Carr & Kemmis as *practical* action research. As has already been stated, key figures within the action research movement (Corey, 1953) have urged teachers to research their own practice. Stenhouse (1975, p.144) said: "*It is not enough that teachers' work should be studied, they need to study it themselves*". Elliot (1987) was of the opinion that the personal interpretive understanding which the teacher brought to the research situation was of paramount importance and that the practice of teaching itself was sufficient to validate the usefulness and legitimacy of the action research approach. Although much of this was discussed in relation to teaching in schools and colleges, I argue that it is no less relevant to teaching within the healthcare professions as the only change is in the institution within which the teaching takes place. As teacher and researcher I bring a unique and valuable interpretive perspective to the research area as not only am I the one responsible for planning and delivering the teaching, but I also share the core professional identity of 'nurse' with most of the research participants and have also been through the very same process which is the main focus for this study, namely trying to incorporate a CBT approach into my work, whilst retaining a core professional identity which is not wholly consistent with that task.

In the design chapter of this study there has already been established and justified, a constructivist epistemological position on knowledge and a corresponding interpretivist ontological position on reality, consistent with a qualitative and more specifically a grounded theory approach. Action research demonstrably shares this philosophy of approach. Because of the key role of this researcher's own perspectives and experiences, which of course are inexorably bound up with the research situation, and because of the active part which the research participants play in attempting to bring about improvements or understandings in their own situation, action research can legitimately be described as *anti-positivist* (Bryant, 1996). Action research comprehensively distances itself from the traditional research paradigm whereby impartial

external academics impose their studies on passive subjects. Once again this is a direct reflection of this researcher's relationship with both the study and the participants.

The main goal of action research is not to uncover an objective reality or truth, which can then be generalised to other situations. In action research, knowledge or truth is created between the researcher and the research participants with the main objective of developing a rich meaningful account of *one particular* reality (Crotty, 1998). McNiff et al (2002) make the highly valid point that because action research is a continuing spiral of process whereby each answer then merely becomes the starting point for further investigation, any true action research studies *must* align themselves with a constructivist/interpretivist position given that knowledge is taken to be fluid and evolving. I would assert therefore that the adoption of an action research methodology is entirely consistent with the stated aims, methods and epistemological/ontological positions of this study. The marrying of two main methodologies, grounded theory and action research, within the one study merits further consideration of overall fit and possible conflict and so is discussed fully in the next section of this chapter.

2.5: The combined use of Grounded Theory and Action Research Methodologies

It is necessary in this section to consider the advantages and potential conflicts of utilising a research design for this study which combines two distinct methodologies, namely grounded theory and action research. An illustration of *how* they are used together has already been provided in chapter 6 of this study. Essentially the grounded theory component of the study maps onto the action research cycle, allowing a more thorough and rigorous approach to the reflection stage of the cycle, by providing a scaffold which allows the critical element of said reflection to be optimised.

The rationale behind the use of this particular combination research design, the *why*, is relatively straightforward. At the outset of this study I had two separate but parallel goals: Firstly I had identified a concern about my routine teaching practice, namely that I had no insight into how, or indeed if at all, the learners

who had attended my various workshops and study days over the years managed to apply what they had learned through the teaching in their clinical practice. Secondly, I had an ambition to obtain a research degree and was aware that in order to achieve this, simply providing a description of how I had improved my teaching practice would be insufficient. I would be required to offer a plausible account of the processes involved which underpinned the learners' experiences in the form of new knowledge or explanatory theory which might later allow for either some measure of either/or verification or generalisation, particularly for a doctoral level of study

The research design therefore had to meet two requirements: Firstly, to fulfil the goal of making my teaching as effective as possible by bridging the theory/practice gap for the learners, and secondly to generate new meaning and understanding in the form of substantive theory. It has already been established earlier in this section that an action research design is ideally placed (McKernan, 1998), to meet that first requirement namely *real world* improvement in the effectiveness of my teaching. Again, earlier in this section, it was established that a grounded theory methodology is a valid way to generate new understanding and theory particularly concerning poorly understood social situations and therefore meets the second requirement of the research design.

It is insufficient however to simply *bolt together* two separate research designs no matter how appealing their apparent utility might be. The two methodologies must both compliment each other and also correspond to the stated ontological and epistemological positions established for the study.

The ontological position I have argued for earlier in this chapter is that of relativism, where it is held that the reality of the phenomenon under scrutiny does not exist independently of context, rejecting the subject-object dichotomy and accepting that my inquiry is inherently value-laden. The epistemological position I have laid claim to is twofold, firstly that the purpose of research is not simply to understand or explain the world but in addition, to aim to change some small part of it and secondly, mirroring the relativist ontological position, that it is impossible to separate the enquirer from the enquired into, and that knowledge about the phenomenon under study will be jointly constructed between the two parties i.e. the constructivist epistemological position. It has

already been established that most action research inquiries work to a relativist ontological position given the emphasis in such an inquiry on the participants acting as co-researchers where "*The principle of collaborative resource presupposes that each person's ideas are equally significant as potential resources for creating interpretive categories of analysis, negotiated among the participants*" (Winter 1989, p.56). In terms of this *particular* study, the reality, which I as the researcher am trying to understand, exists as a joint construct, in equal measures of my experiences teaching the learners and equally their collective experience of being taught by myself.

Similarly, the adopted constructivist epistemological position hinges on that same premise of mutuality between researcher and participant. Mills et al (2006) highlight that traditional grounded theory deriving from Glaser and Strauss' original (1967) text did tend to adopt a more objectivist epistemological position, namely that if process is followed correctly then the researcher can from a distance, describe and understand an objective truth without unduly influencing what is being studied. Equally, its ontological standpoint was that there *is* an objective reality out there but it can only be imperfectly perceived. In describing a constructivist approach to grounded theory, Mills et al advocate a rethinking of the researchers' traditional role as objective observer broadly in line with the *anti-Glaser* stance adopted by Cathy Charmaz and described in detail earlier in this section whereby a greater level of reciprocity is created between researcher and the participants in the construction of meaning and ultimately theory, and the realist/objectivist roots of grounded theory are rejected for being both impractical and also unhelpful in that they deny the researcher the opportunity to use potentially valuable, sensitizing knowledge.

Perhaps the best example from the literature, which illustrates and justifies the marrying of the two methodologies, lies in the concept of *Grounded Action* (Simmonds & Gregory, 2003). They define it thus: " (grounded action) *...is inductively derived from the study of the phenomenon it represents for the purpose of creating and applying practical solutions to social systems."* In effect a highly apposite summary of the combination research design in this study. They go on to offer a compelling justification of the use of grounded theory within an action research project:

"...Like all other aspects of a grounded action project, all actions must earn their way; they must be ultimately traceable back to and supported by data. The calculated actions constitute an empirical test of the explanatory and or operational theory. Its actions are fully grounded in dense, rich explanatory and operational theories they should significantly mitigate the action problem" (Simmonds & Gregory, 2003 p. 9).

What they are saying is that if the action part of the research is based directly on the grounded theory analysis of the research data then it will share the same rigorous foundations as the grounded theory analysis and be more likely to have direct relevance and benefit to the problem at hand. If one considers the application of the grounded action model to this study, then it can be seen how a direct line can be drawn from the modifications made to my teaching (the action) through the grounded theory analysis and ultimately to my research data, as Simmonds and Gregory put it, *Grounded Action* indeed.

Simmonds and Gregory's work can be seen as a critique of grounded theory, drawing attention to the fact that once the theorising is complete then so the research stops. Dick (2003) levels a corresponding criticism of action research; echoing the observations of other researchers (Baskerville & Pries-Heje, 1999) when he asserts that action research is a methodology which is poor at generating theory.

Dick (2003) and Simmonds & Gregory (2003) therefore highlight the main limitations of the action research and grounded theory respectively. Action research is a good *doing* methodology but is poor at explaining *why?* Whilst the weakness of grounded theory is that although it fulfils its own stated purpose in the generation of theory grounded in data, it does not offer an operational theory, which might allow that new understanding to be translated into real-world action either for the purposes of verification or for problem-solving. Dick (2003 p.2) summarises neatly: "*Grounded theory tends not to be participative. The action tends to be someone else's responsibility*". It seems reasonable to suggest therefore that the utilization of a combined action research/ grounded theory research design within this study, affords this study with the rigor of grounded theory allied with the real world pragmatism of action research. One potential area of fundamental incompatibility between the two approaches is the thorny issue of participation. Some prominent action research researchers such

as Carr & Kemmis (1983) advocate that action research is only action research if it is participatory. Whilst it has already been demonstrated that grounded theory (as practiced in this study) utilizes a constructivist epistemology and a relativist ontological position, the actual analysis and theory development was the solitary task of this researcher. Dick (2003) however adopts a similar perspective to the one adopted earlier in this chapter where participatory action research was instead considered instead to be just one form of action research alongside the self-reflective and practical models of action research, which this study more closely mirrors. Dick suggests that it is perfectly valid to consider action research outwith its ideological roots and instead exploit the inherent value of the planning, action and reflection cycle for its own sake, suggesting indeed that: "*it would be a pity to limit it to situations where participation is possible and appropriate*". Once again, just as it was necessary to define which camp or philosophy of grounded theory (constructivist) was being utilized within this particular study, so it has also been necessary to define which particular form of action research has been adopted (self reflective/practical), in order to present them as being consistent with and complimentary to the overall research design for this study.

There appears then to be a strong justification for the marrying of the two approaches, if as in this study, the research aim is not only to bring about change or improvement, but also to provide rigorously developed theory with strong explanatory powers which might allow for either some generalisability of the improvements or at least further development verification of the theory. Although Baskerville & Pries-Heje (1999, p.2) caution that "*grounded theory stands unchanged as a suitable qualitative research technique in settings where researcher intervention is not a primary goal of the research* " they conclude that the merging of a grounded theory analysis phase within an action research study leaves us potentially with a "*theory-rigorous" and powerfully improved action research method*", a summary which I would certainly endorse.

2.6: The use of reflexivity as a tool within the research project

2.6.1: Introduction

This section addresses the concept of researcher reflexivity. Given that this study employs a qualitative methodology, it is inevitably a work which will refer to itself. It must however equally inevitably defend itself against the familiar accusations of subjectivity and researcher bias commonly levelled by advocates of the positivist or objectivist paradigm (Kamin, 1977; Freeman, 1983). Qualitative research studies do not have the ready-made measures of validity namely statistical evidence, rigid adherence to pre-determined research design and tight experimental control afforded to their quantitative counterparts. It has been successfully argued however (Lincoln & Guba, 1986) that since qualitative studies locate themselves within a philosophical position which is broadly 'interpretivist' in nature whereby the concept of a single reality to be discovered is replaced with multiple realities constructed by individuals or groups varying according to context, then meaning not truth becomes the focus for the research and the positivist criticisms are rendered effectively redundant. In effect the social constructionist perspective. (Gergen, 1985).
Qualitative research must instead look to other means to ensure the integrity of any studies. Evidence of researcher or self-reflexivity is one of the main criteria by which the quality or rigour of any qualitative inquiry can be judged (Patten, 2002; Fisher, 1994). Potential researcher biases must be acknowledged and in essence the researcher must endeavour to create a zone of objectivity about his/her subjectivity.

2.6.2: The use of reflexivity within research

There are several differing but complementary definitions of the term reflexivity which merit inclusion here: Setting aside the issue of epistemological reflexivity which is addressed elsewhere in this thesis, the definition proposed by Nightingale & Cromby (1999, p.228) perhaps comes closest to capturing the personal reflexive style I hope to use within this thesis.

"Reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgment of the impossibility of remaining 'outside of' one's subject matter while conducting research. Reflexivity then, urges us "to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research."

Etherington (2004, p.47) focuses on the consequences of such an undertaking claiming that "*It opens up a space between subjectivity and objectivity where the distinction between content and process becomes blurred*" whereas Shacklock & Smyth (1998) develop the definition further by including the need for awareness of broader historical and socio-political values on the research. For feminist sociological researchers e.g. Lentin (1994), the power base of the dominant (i.e. scientific) research methodologies can be viewed as reflecting a male versus female, subject versus object and knower versus known divide. The feminist standpoint views reflexivity as one means of placing the researcher on the same plane as the research participant whereby there is a reciprocal sharing of knowing. The use of reflexivity as a tool within social research however has not been without its criticisms. Marcus (1994, p.569) levels accusations of "*dead end self-indulgence, narcissism and solipsism*". Woolgar & Ashmore (1988, p.7) refer to reflexivity as the "*epistemological horrors*" whilst Ashmore (1989, p.234) describes it as the "*monster: the abyss, the spectre, the infinite regress*".

Martyn Hammersley (2005) rightly points out that researcher reflexivity is no guarantee that research will be done well and indeed that since time is invariably in such short supply in any research project then there is the danger that the more time is spent on reflexivity then the less time is left to actually do the research itself! My own belief is that whilst there are elements of truth to these criticisms, if one accepts that social enquiry at its core rejects any notion of naive realism i.e. that there is one unequivocal reality or truth to be discovered (Mays & Pope, 2000) but instead places the researcher along with the researched in a reality which is co-constructed between the two, then the constructivist researcher is forced to acknowledge his/her role in constructing the reality of the subjects (Ravn, 1991). Reflexivity then allows the researcher to "*hear what our subjects are telling us, not by imposing our categories on*

them but by seeing how our categories may not fit" (Steier, 1991, pp. 7-8). Although my identity within this written report is essentially "the researcher" I carry with me the values, opinions and motives from in excess of 25 years experience in a multitude of roles both clinical and educational. Even within the confines of this research project I am not only the researcher but also the teacher. For most of the participants in the study, they know me first and foremost not by those recently adopted and at times ill-fitting roles but instead as a colleague, a nurse and in some cases a friend. During the interview process it quickly became apparent that many of the participants had dissatisfactions and difficulties in various aspects of their which clinical roles which in certain ways had influenced or motivated them to volunteer for the CBT training. Some felt that participating in the training would afford them the skills or career advantages to be able to resolve some of those issues. Inevitably then I also became a confidant, a receptacle for their concerns, which I then felt obliged to treat with the same respect, and import, which I would assign to any of my patients' problems. I felt to an extent burdened by these problems, knowing full well that I was in effect powerless to directly influence them, and unbeknownst to them was actually experiencing many similar difficulties myself, but at the same time humbled and privileged to be trusted with their accounts. The need therefore to somehow untangle or at least bracket and acknowledge the myriad of potentially conflicting ways in which my own subjectivities might influence my construction of these participants' stories becomes paramount. In the following section I outline four of my own 'voices' which compete to tell their own stories within the research:

2.6.3: Personal reflective positions

a) Self as Cognitive Behavioural Therapist:

Jokingly, over the years many of my colleagues have addressed or referred to me as "*Mr CBT*" an appellation which although well intended and always accompanied by a wry smile, nevertheless inevitably makes me cringe. My staff identity badge identifies me as a cognitive behavioural therapist, it is the basis for my seniority and grading, and it is what motivates colleagues to turn to me for advice and supervision as well as providing my own internal justification for

what I do. I was the first nurse, or indeed any other health care professional, based at my hospital who had formally trained in CBT and also the first to accreditation with the relevant professional body. I therefore became the standard bearer for CBT within my own admittedly somewhat insular and limited clinical environment. I offered training and supervision to a variety of disciplines from dentists to doctors, worked closely with general practitioners and other potential referrers to develop awareness of what I, and CBT in general could offer, screened and/or treated between 80 and 90 patients per year and eventually was included within the core teaching staff for the same university diploma course which I had recently graduated from. Looking back on this experience I allowed my own identity to perhaps become too closely aligned with my chosen therapeutic orientation. The name Steve Martin became synonymous with the term CBT within my locality. I had trained as a CBT therapist for essentially pragmatic reasons, i.e. I wanted promotion, I wanted 'out of the wards', I desired autonomy and if I am honest, the status which I felt such a post would afford me. Whilst I was successful in my ambitions I did not fully realise the extent to which I would become "Mr CBT" its advocate and its defender. I became socialised into the wider 'CBT community' through CPD events, the professional body for CBT (the BABCP), association with other nurses eventually following in my footsteps and my input to the CBT course. This felt quite distinct and separate from my previous 'membership' of the generic nursing community. My socialisation continued through the subscription to and review of the CBT literature, which was, and still is, overwhelmingly positivist in its methodology. Journal articles reviewed the efficacy of computer-based CBT, employed "time base lag sequential analysis" to understand case studies and in general, the randomised control trial set the gold standard for research quality. To then attempt an impartial analysis of how staff *experienced* training in CBT employing a 'soft-science' qualitative methodology to develop understanding and meaning rather than to prove, predict or explain causal relationships required me to both set aside old ways of knowing and also be open to a whole new epistemological position.

b) Self as teacher.

At the same time as I was undertaking the teaching and data collection for first two cohorts to be included in this study, I had also been seconded to an associate lecturers post at a local university in the school of nursing and midwifery, teaching to pre-registration nursing students in both the core and branch programs as well as having input to post registration programs. At the time I was acutely aware of having stepped out of a familiar, even safe, longstanding professional identity as a psychiatric nurse into something really quite alien. The terminology and jargon was unfamiliar to me, the criteria by which I might be judged and in turn I should judge my students was unclear. I was no longer a senior member of staff of some 15 years service who was on nodding terms with everyone in my institution but a novice, a beginner who was unsure how to even requisition a packet of envelopes. At the same time I was also studying through the Open University to gain accreditation as a teacher in higher education, following a masters level course. Inevitably this involved some assessment of my teaching through observation by my colleagues, submission of lesson plans and the maintenance of a reflective diary amongst other means of assessment. I therefore on reflection, approached my CBT teaching sessions with a far greater need to somehow prove myself as a *good teacher* than if I had simply been extending my role as a clinical nurse specialist. I wanted to pass the course, to prove that I could succeed in this new role as I had in my previous one as a nurse/therapist. I wanted to give my students the best possible experience learning environment I could, to use all my principles of andragogy, to facilitate the students learning, to avoid any suggestion of old fashioned pedagogical notions of imparting my sage like wisdom and a million other considerations. Once again I brought with me motivations and values which might easily be considered incompatible with my stated aims as a researcher to understand my students' experiences warts and all and not only accept but embrace the implicit possibility that there may well be some negative reactions to either myself, my teaching or to CBT itself which of course I had placed myself in the role of unofficial ambassador for.

c) Self as nurse

Since the early 1990's there has been an ongoing revolution in nursing, both general and psychiatric, whereby traditional roles between nurse and medical staff in particular have been broken down. In general, nursing nurses powers of prescribing medication continue to increase and the introduction of nurse led clinics for such specialisms as midwifery are now commonplace. In psychiatric nursing the emergence of accredited CBT trained nurses has further challenged the established hegemonies and now these nurses will typically assess and treat patients directly referred from primary care with those patients never seeing a consultant psychiatrist. The journey I took, by moving away from the traditional medical model of nursing care to a specialism which was not *owned* by medical staff, where they could not claim superiority in training or knowledge, whilst rewarding did bring me into areas of conflict with those medics, admittedly in the minority, who clung to the old assumptions concerning roles, as well as with some clinical psychologists who felt I was encroaching on their territory. Perhaps more surprisingly I also faced some resistance from my own core profession i.e. my nursing colleagues. I had gained promotion quickly, was able to function with a greater degree of autonomy than they did and I suspect was thought by some to have *ideas above my station.* There was an element of truth to this. I straddled two separate disciplines, nursing and psychotherapy. At times this felt uncomfortable, perhaps I was neither in reality. Unfortunately my *neither one thing nor the other* position left myself and two of my fellow psychotherapy trained colleagues exposed. When a 'financial recovery plan' was deemed necessary within the healthcare trust the, service our small band of nurse therapists had established was 'retracted' we had to undergo a difficult period where management attempted to integrate us into existing staff structures despite there being no easy fit. Since that time (2003) there has been a constant battle to retain a specialist role in the face of sustained pressure to conform to generic stereotypes. Concurrently as I was both teaching and interviewing the (largely nursing) participants for this study, they, as I had previously done, saw the CBT training as a step towards career development, an endeavour which surely could not fail to yield anything other than positive consequences. Once again I was aware that there was the danger that my own experiences, my own cynicism and jaundiced view might well, if not acknowledged, lead to a lack of

objectivity in my analysis of the data as well as potentially leading the interviews according to my own 'issues'.

d) Self as researcher

Janesick (1998, p.36) states that "*qualitative research design begins with a question*". Many notable publications on qualitative research design (Denzin & Lincoln, 1998) contain an implicit assumption that a commitment to a qualitative research design has already been made as the first step on the journey. Whilst that is not an unreasonable standpoint, there is however a duty for me to describe fully *all* the various stages through which this study has passed, including those crucial influences which preceded the formulation of the research questions but which nevertheless profoundly affect the ultimate research design.

My own journey as a researcher began not with a burning question to answer or even an interest in a specific area for research. Instead, for personal reasons including career development, promotion and status I sought to gain a research degree either MPhil or Ph.D. In order to be considered for this I had to therefore submit a formal research proposal, which I hoped would be accepted by a university or college. Such a requirement imposes an initial need for structure and definition to a research project. A title and a theoretical framework had to be identified. A timescale had to be outlined and ethical considerations discussed. Evidence was required that I had access to both the research setting and suitable subjects and that I had reviewed the relevant literature and identified an area for research where there was a poverty of understanding or information. All these factors began to impose structure on the study which would ultimately inform the choice of design. Holliday (2002) refers to the concept of "Opportunistic research" to describe the pragmatic way in which many qualitative researchers capitalize on situations which arise, for example, in the workplace which either suggest an interesting area for research or allow an opportunity to follow-up or develop a long-held interest. Qualitative research is fundamentally about *real-life* situations where the researcher frequently has close connection to the research environment or subject/subjects. Nurses (Titchen & Binnie, 1993) and teachers (Kasworm, 2005) frequently, due to economic realities and staffing limitations find themselves in situations where

research activity has to somehow co-exist with *core* professional activities. It is not surprising therefore that in each of these milieu an inclination towards the qualitative methodologies, the concept of the nurse or teacher-researcher, fieldwork and case studies are commonplace. In my own situation I combined a clinical role carrying out CBT and was often called upon to teach. I had also negotiated one day per week dedicated research time for the pursuit of my research degree. It was clear at the outset of the planning stage for this research project that given that I was not part of a research community *per se*, (indeed after a few phone calls I discovered I was in fact the only nurse within my hospital carrying out any kind of formal research) I would have to be essentially self-sufficient, with the exception of academic supervision, during the study. This even extended to the realisation that I would have to transcribe all audiotapes myself due to the prohibitive cost of employing an audio-typist. All of these factors greatly influenced the form the eventual research project took. Although I had no experience of it, at this early stage a qualitative study seemed likely to be more manageable under the afore mentioned conditions.

Whilst the literature is full of references to the validity and intergrity of various research methodologies, I was at the beginning of this study, acutely aware of my own admittedly subjective prejudices and preferences for and against particular methodologies. My own academic and professional history exposed me almost exlusively from the ages of 17 to 37 to a traditional scientific or quantitative scientific paradigm. I had studied the biological sciences to degree level at university, worked in clinical and research laborotories and had also spent the six years preceding this study working in the CBT milleu with its again predominantly quantitative methodology, reliance on statistical proof and so on. The prospect of undertaking a formal research project was daunting in itself but the prospect of quickly orienting myself to an entirely different scientific paradigm added even more to my anxieties. A preliminary review of the qualitative literature suggested that grounded theory more than any other qualitative methodology might be most comlimentary with both my status as a novice researcher and as someone who had only ever really considered the traditional logico-deductive paradigm. Charmaz (1995, p.27) described grounded theory methods as providing "*a set of strategies for conducting rigorous qualitative research*" going on to suggest that "*these methods make the*

strategies of gifted qualitative researchers explicit and available to any diligent novice." I was rapidly being convinced! The prospect of a rigorous approach helped counter my prejudices against *soft science.* Grounded theory has also been described as meeting many of the key accepted cannons of good science, namely consistency, reproducibility and generalisability and also derives any theory generated from close ties to empirical data. In addition the explicit analytic procedures being outlined (Glaser & Strauss, 1967) was a welcome contrast to the textbooks which began by describing qualitative research as **not** being a unified set of techniques or philosophies (Mason, 1996 p.3) and describing the 'qualitative researcher as *bricoleur'* metaphor (Weinstein & Weinstein, 1991) The prospect of having to become a 'Jack of all Trades' was particularly daunting given that I did not at the time feel I had **any** tools of the trade to bring to the problem never mind a *bricolage*!

Reflecting on my instinctive affinity for grounded theory, I see now that I was attracted by its alleged scientific credentials, I considered it to be in effect the most realist of the anti-realist methodologies.

Once actually engaged in the research process I experienced many of the same anxieties and concerns which I outlined in the previous section 'Self as Teacher'. As with that experience I was/am perhaps more concerned with 'getting it right' than a more experienced researcher. I continue to have a fear of failure, a desire to win the approval of my supervisors and peers within the academic institution where I study and also of the wider research community in general. As was the case with my motivations for originally undertaking the CBT training, a large part of my future hopes and ambitions are tied up with the success of the PhD and therefore with the study itself. Although over the years I have been carrying out this research I have succeeded in developing a less rigid definition of what might constitute 'success' within a qualitative research project, I was nevertheless acutely aware, particularly whilst carrying out the interviews with the research participants, that I was hoping to hear "*interesting*" "*relevant*" and "*revelatory*" accounts of their experiences training in and attempting to apply the CBT approach. Again through the benefit of self-reflection and good supervision I hope I was able to avoid unduly influencing the direction of the interviews so that I might hear ***what I wanted to hear***

instead of allowing the data to emerge as well as developing a less narrow, more realistic definition of just what constituted 'good' data.

2.7: Ethics, its relationship to qualitative research and the adoption of an underlying ethical stance for this study

2.7.1: Introduction

In this section the issue of ethics shall be reviewed, in particular its relationship and relevance to qualitative research as well as describing and justifying the underlying ethical approach, which was used to guide the conduct of this study. An account of how specific ethical considerations such as confidentiality were applied during this research process is provided within the Method chapter of this thesis.

2.7.2: The meaning of ethics and its relationship to qualitative research

Ethics is the study of how individuals and groups behave according to moral principles. A useful distinction to make between morals and ethics is that ethics are essentially a social construct whereby a moral code is taught or argued and then adopted by for example a religion, a professional body or a culture as a system of guidelines for moral behaviour.

Ethics is typically divided into three subsystems: normative ethics, metaethics and applied ethics. *Normative ethics* attempts to establish universal norms or standards of conduct. *Metaethics* is the study of the nature of the judgement and the theories of ethics. The third subsystem, *applied ethics* is the one with most relevance to this study and as the name suggests relates to how ethical codes are applied in various practical real-life situations such as the legal system, governmental policy and scientific research.

The foundation of the ethical regulation of scientists, and therefore research, was the Nuremberg code which emerged out of the Nuremberg trials of Nazi doctors and scientists at the end of world war two. It was found that these doctors and scientists had experimented on imprisoned subjects against their will and often with consequences which were either fatal or resulted in extreme

harm and/or suffering. A code of ten rules was established to govern future research with human subjects, principally to minimise the risk of harm or suffering to the subjects but also, highly significantly, introducing the concept of *informed consent.*

This study however, as already established in the methodology chapter is not conducted under a scientific or experimental paradigm whereby subjects are neither *experimented on* nor are their physical, environmental or emotional states are manipulated in some way. Qualitative research is concerned with understanding the lives of individuals in specific social, cultural or historical contexts with particular emphasis on the meanings or constructed realities of either individual or small groups rather than an emphasis on the search for universal or generalisable laws or truths. This is not however to say that qualitative research is somehow above the need for careful ethical consideration. Bogdan & Biklen (1992) assert that the primary concerns for the ethical conduct of qualitative research remain those of informed consent and protection of participants from harm. In qualitative research however, the meaning of the term harm is likely to be a far more general one, including emotional, psychological and spiritual harm, in comparison to the description within the Nuremberg code, which largely related to actual physical harm.

In qualitative research and specifically the action research paradigm employed in this study, the relationship between the researcher and researched becomes less that of scientist and subject and more like that described by Winter (1989, p.45) where: "*Participants in an action research project are co-researchers. The principle of collaborative resource presupposes that each person's ideas are equally significant as potential resources for creating interpretive categories of analysis, negotiated among the participants. It strives to avoid the skewing of credibility stemming from the prior status of an idea-holder. It especially makes possible the insights gleaned from noting the contradictions both between many viewpoints and within a single viewpoint*".

The philosophy of action research diverges even further from the traditional scientific paradigm particularly in the field of education, when the following quote is considered: "*Action research is a form of self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own practices, their understanding of these*

practices, and the situations in which the practices are carried out" (Carr & Kemmis, 1986. p.162). Effectively Carr et al are stressing that in action research the researcher is often as much the subject of the research as are any research participants. Accordingly then, the main focus for ethical concern in qualitative research becomes that of *relationship* (Haverkamp, 2005) or how that key relationship between the researcher and the research participants is conducted.

There follows a description of the most common ethical frameworks used to guide qualitative research studies and an account of this researcher's efforts to derive an ethical position consistent with the overall methodological and ontological position of this study from an amalgam of these extant positions:

Kvale (1996) describes three ethical models, each offering different frameworks, which allow one to reflect on ethical concerns within qualitative research. The first '*the duty ethics of principles*' reflects the deontological model most notably first suggested by German philosopher Immanuel Kant. In this model researchers (or indeed any individual) are considered to be beholding to *a priori* moral obligations or duties such as honesty, justice or respect, which should always be adhered to regardless of circumstance. The second model proposed by Kvale, '*the utilitarian ethics of consequences*' prioritises the benefits of the outcomes of research in ethical decision-making. Taken to extremes this can be taken to mean that the ends justify the means and can be a difficult ethical position to sustain. The third model suggested by Kvale differs substantially from the previously mentioned two in that it is not a *universalist* model. Effectively both these two models suggest the application of universal abstract principles regardless of context or the specific research situation. The third model '*virtue ethics of skills*' adopts a contextualist approach to ethical decision making, suggesting that the researcher uses his or her internalised morality and reflexive skills to reflexively negotiate ethical dilemmas in negotiation with the research participants and according to their specific concerns. A fourth model with strong similarities to the virtue ethics of skills, is the feminist value-based model as described in Edwards & Mauthner (2002). This model employs feminist-based social values such as care and responsibility to guide ethical judgement. In common with the virtue ethics model it shares a "*morality of context*" (Almond 1998, p.120) and views research participants as specific individuals located in specific situations rather than stereotypes such as

'vulnerable persons'. Accordingly the relationships between researcher and participant become individualised and context specific and so require a flexibility and responsiveness of approach to ethical considerations that the universalist models are ill-equipped to provide. Not surprisingly therefore these contingent, virtue/value approaches have become the predominantly advocated approaches to ethics in social research in recent texts (Edwards & Mauthner, 2002).

2.7.3: The choice of an ethical framework for this study

My own position is that the ethical approach which I utilise within this study, must be consistent with the two main methodologies used to conduct this research namely action research and grounded theory. As already stated elsewhere in this thesis, a key aspect of action research is reflexivity, reflecting critically (in the case of educational action research projects) on ones own performance as an educator (McNiff et al, 2002). Also in action research, the goal is not to discover an objective truth or reality, rather it is an attempt to negotiate and construct meaning between the researcher and the research participants (Norton, 2001). Accordingly I consider it reasonable to reject the adoption of either of the universalist ethical models. Given that the research process is uniquely constructed between the reflexive efforts of the researcher and the individual perspectives of the research participants, is continually evolving and is highly contextualised, then so must the ethical approach reflect this. Attempting to apply abstract universal principles to the ethical issues raised in such a research methodology would be incongruent with the overall philosophy of approach. The adoption of an amalgam of the contingent virtue and feminist value models advocated by Almond (1998) and Edwards & Mauthner (2002) offers I believe, an ethical framework which *is* entirely consistent with the methodological approaches of this study. It shares a common system of values with action research in that as mentioned earlier, the research participants are treated as individuals for whom any ethical duty of care will be applied reflexively according to circumstance. The feminist value model has particular appeal, as unlike the virtue ethics model it accepts that ethical decisions can never be impartial or neutral and that a researcher's own

inevitable partiality will influence the power basis of researcher/participant relations. The concept of naïve inductionism has already been rejected whilst considering the grounded theory approach elsewhere in this study. I have acknowledged my proximity to the research subject matter and argued for the position of Charmaz (2000) in relation to the influence of prior knowledge on the coding process in grounded theory, namely that it is both impossible and actually disadvantageous to somehow set it aside. Accordingly the adoption of aspects of the feminist value system of ethical consideration whereby the *partialities* of the researcher are explicitly sought, bracketed and considered of value to the research process (Porter, 1999) displays a consistency of approach across the study.

Attempting to adopt a given ethical standpoint for any study which employs a grounded theory methodology, poses significant difficulties. Grounded theory is of course an *emergent* research design. The researcher traditionally begins a study using GT without a specific research focus or question in mind but instead adopts, as Barney Glaser (1992) memorably suggested an outlook of "*abstract wonderment of what is going on that is an issue and how it is handled*" (p.22). Ramcharan & Cutcliffe (2002) describe the typical difficulties which ethical research committees have with approving emergent qualitative designs where the direction of the study is not yet known, where the ethical issues which might arise between the researcher and the participants cannot yet be anticipated and even sample sizes are at best an "*educated guess*" (Stern 1991, p.149). Guillemin and Gillam (2004), offer a suggestion as to how to respond to this challenge by describing instead the need for the researcher to be attuned and responsive to "*ethically important moments*" (p.262). These are in essence, times during the research process where the researcher recognises that a contemplated action or decision may result in harm or wrongdoing, and therefore has an ethical dimension to it which requires consideration and reflexivity on the part of the researcher. Although Guillemin and Gillam suggest that professional guidelines might provide guidance for the researcher at such times. Haverkamp (2005) rightly raises the probability that given the realities of the research situation the decision on *how* to apply such universalist guidelines be well remain ambiguous. Kitchener (1984) suggests a decision making process which begins with the researcher utilizing his or her unique situational

and context specific knowledge of both the research situation and the research participants. The second tier of decision making in Kitcheners model is to then draw guidance from ones own professional standards. In this researchers case I would have both the Nursing and Midwifery Council (NMC) as well as the British Association of Behavioural and Cognitive Psychotherapies (BABCP) codes of conduct to draw upon. The final tier of decision making, if the previous two have failed to bring about a satisfactory resolution of the problem, is to then turn to formal ethical theory in order that an ethically defensible position might be adopted. Kitchener's model has much in common with the contextualist virtue and/or value stances advocated earlier in this section and also allows us to utilise Guillemin and Gillam's concept of ethically important moments to meet the challenge of an emergent, grounded theory research design. A particular virtue of Kitchener's model is that it allows the novice researcher working outwith the support of an established research environment the safety net of his/her familiar professional guidelines which in this researchers care have been internalised through twenty and twelve years practice according to the NMC and BABCP guidelines respectively. It also however allows this researcher primarily to use a contextual position, which Haverkamp (2005, p.150) accurately describes as being "*congruent with the importance attached to subjectivity and context in the axiology of most qualitative paradigms*".

2.7.4: Section conclusions

It is logical to summarise and offer final justification for the ethical position described above, and adopted from the outset of this study, by describing a particular experience from the data-gathering phase of this study, in actual fact the experience which forced me to consider my ethical stance: As I have already described above, I began this research project, in keeping with the grounded theory design, with a broad idea of the area which I proposed to study. Given that no patients were involved in the study the local ethics committee granted immediate approval to the research proposal, and since my research participants were colleagues who I considered amongst my peers, I was confident that the potential issues of power imbalance which I had read about in qualitative research textbooks could be avoided. I was forced however to begin to

contemplate the decision making process regarding my own ethical stance which in effect is reflected in the preceding paragraphs of this section once I began to interview my first research participants. My phenomenological response to what the research participants were telling me (an experience and a response which was consistent throughout the two years of the data gathering) felt innately similar to my response when typically working therapeutically in my main role as a psychotherapist with a patient who was disclosing sensitive, personal information with a significant emotional overlay. I had not expected this; I had not at the time read other researcher accounts of a similar phenomenon, which might have prepared me for this experience. In my work as a therapist I am acutely aware that such disclosure entails a duty of care and trust towards my patients. When I listened to the research participants describing their hopes and fears, their dissatisfactions with aspects of their careers and their struggles to do their best for their own patients, I experienced a similar feeling of obligation to the research participants to treat them with the same ethical sensitivity which I hope I treat my patients with. I would class this in Guillemin & Gillam's terms as my first ethically important moment. Perhaps the highly personal nature of how the participants discussed their experiences with me should not have came as such a surprise. Haverkamp (2005, p.151) summarises the position of those with primarily psychological clinical backgrounds conducting qualitative research interviews thusly: "*(psychologists are) uniquely well equipped to conduct such interviews in a way that will elicit rich, elaborated data. Particularly in comparison to our qualitative colleagues in other disciplines, our clinical training enables us to gain the trust of participants and to facilitate disclosure.* She goes on however to make the highly relevant point that such skills bring with them responsibilities "*The more adept we are at creating a sense of connection and engagement, the more we need to be attentive to issues of power, influence, coercion, and manipulation".* Returning to the decision making process of Kitchener (1984) outlined above, I believe I was able, in that first tier of that decision making process, to reflexively use my own understanding of the situation through my intuition, experience and sense of moral value built up over twelve years of psychotherapy practice in the, effectively employing the aforementioned amalgam of virtue ethics with a feminist value-based position, namely the need

for care and trustworthiness, to negotiate my way through this first *ethical moment*. I did this by steering the conversations through a balance of maximising the opportunities to gather rich relevant information but simultaneously making a conscious effort to avoid turning the interviews into therapy sessions. During some interviews when it became clear that the participant wanted to discuss issues which to me felt of a more personal nature and therefore outwith the boundaries of the study itself. Admittedly this was an entirely subjective judgement call but based on a great deal of clinical experience. I allowed him or her to carry on the conversation after the tape recorder was switched off. In all these cases my prediction that the conversation should remain private, was I believe, proved correct. On a couple of occasions I did refer to the BABCP code of conduct, not to address any specific ethical concerns as per tier two of Kitchener's model, but as a general refresher so that should the virtue/value amalgam I had been employing as my *first line of defence* prove insufficient then I would have the reassurance of familiarity with my professional ethical guidelines.

In conclusion, because this has been a qualitative study whose direction has emerged over its course, I have chosen an ethical framework which I believe is consistent with this. The key requirements of the ethical framework has been to allow this researcher to behave in a reflexive and responsive ethical manner, reflecting the both individuality of the research participants as well as the fact that the ethical issues could not have been anticipated at the beginning of the study, and also to meet the moral obligations of a duty of care towards the research participants and deal with their disclosure in a sensitive and appropriate manner. I believe that the adoption of the amalgam, virtue ethics/value-based feminist model throughout this study, has provided this due largely to the scope it afforded this researcher to legitimately use my existing ethical sensibilities and apply them in a sufficiently rigorous way, whilst continuing to acknowledge and bracket the personal and emotional dimensions which both this researcher and the participants brought to the relationship.

Chapter 3: Methodological Considerations

3.1: Data Collection and Analysis

3.1.1: Contextual orientation to the data collection

The teaching interventions which formed the basis for this study, consisted of four series of six one-day workshops, each held weekly. The cohorts in series one, two and four were composed mainly of nurses and provided the data for the main part of the study. Cohort #3 consisted of occupational therapists and was treated as a separate study for the purposes of triangulation. Data collection and analysis was however carried out in an identical way across all four cohorts.

An additional four interviews, again for the purposes of triangulation were also carried out with students on the Diploma in Cognitive Behavioural Therapy course run by the University of Dundee in the months between series two and three of the workshops

Each of the four series of workshops were held approximately yearly. Those for the mainly nursing cohorts were held in the psychiatric hospital where both the learners and myself were based, as part of an informal in-service training programme. The occupational therapists attended the workshops in two training rooms in a nearby general hospital where many of them were based

The content of these workshops was essentially an introduction to cognitive-behavioural therapy (CBT), its theoretical basis and its application to the more common mental disorders for which its efficacy had been empirically established.

A full account of the teaching plan and content of these workshops is provided in the Methods chapter of this thesis.

Table 1 (overleaf) details the composition of the four main cohorts plus the supplementary (Dip CBT) respondents, the number of interviews conducted with each and when the various cohorts attended the workshops

Cohort	Composition	Total No's	No Interviews	Date
Cohort #1	PCLT (nursing)	6	8 (6+2f)	2001
Cohort #2	Generic nursing plus 1 x OT	9	5	2002
Cohort #3	OT	9	9 (7+2j)	2004
Cohort #4	Generic nursing plus 1 x physiotherapist	10	7 (6+1j)	2005
Supplementary	Dip CBT 1x Nurse/psychiatrist/OT/clinical psychologist	N/A	4	2005

Table 1: Summary of composition of cohorts, total numbers in each, numbers of interviews conducted within each cohort, and the year the workshop was held (or the interviews were conducted in the case of the Dip CBT students).
Where the number denoted by the + sign is indicated, that denotes either a focus group (f) or a joint interview (j) with 2 research participants.

3.1.2: The Data Collection

The data collection consisted of a series of audio taped interviews both with individual participants, pairs of participants and two focus groups, each of these from cohort #1. Once recorded onto audiotape, the data was then manually transcribed verbatim onto double spaced A4 paper.

The data collection and analysis was carried out exclusively by the author, partly because of pragmatic considerations but also in order to maximise the potential for understanding which occurs when the grounded theorist engages in data collection as well as analysis, affording a greater sensitivity to the more subtle nuances of meaning and process under analysis. (Charmaz, 1995)

Cohort #1.

Cohort #1 were initially interviewed as a focus group 2 weeks after the final workshop. Focus groups are established as effective ways of exploring the attitudes and needs of health service staff (Denning & Verschelden, 1993), and can utilise group processes to help people explore and clarify their views in ways that would be less easily accessible in a one to one interview (Kitzinger, 1994). This was followed up by individual interviews with each of the team when opportunities presented over a 2-month period following the focus group. The interview with the senior charge nurse was different in that its focus was on how the workshops had impacted on her staff.

A second focus group was held four months after the teaching had finished.

Cohort #2

Due to the mixed composition of this group it was not possible to assemble them for a focus group, post training. Individual interviews were therefore the main source of information.

Cohort #3

See separate occupational therapy study

Cohort #4

This group was broadly similar in its heterogeneity to cohort #2. Accordingly it was again impractical to assemble them for a focus group but two of the interviews were conducted with two of the participants present.

3.1.3: Interview Procedure

All interviews conducted for this study were formal in that they were pre-arranged with the informants for the specific purpose of data collection. Initial interviews were largely unstructured although they were clearly informed by the area under study and this author's initial literature search (see chapter 2).

Subsequent interviews became more semi-structured (Polit & Hungler, 1987) as areas of interest generated by emergent theory from earlier interviews were followed up, but were always flexible enough to allow new leads to be followed as intuition suggested during the interviews thus allowing the emerging theory to be developed. One of the semi-structured interview schedules used for cohort #3 is included in the appendices to this thesis.

A variety of rooms either in the general or the psychiatric hospitals were used to conduct the interviews. These tended to be selected by the participants themselves because of their proximity to their workplace. Several participants actually gave up their lunch hours or stayed late to attend the interviews.

A small portable tape recorder was used to record the interviews. The participants were advised in advance that the interviews were to be taped. I generally spent approximately ten minutes before turning on the tape chatting generally to the participants, telling them how my research was going and trying to put them at their ease. All the interviews lasted under 45 minutes i.e. within one side of a C90 audio cassette tape.

3.1.4: Sampling

The initial sampling was of cohort #1 the Primary Care Liaison Team (PCLT). This was total population sampling as described in Morse (1991). This was possible due to the relatively small number of informants (six) and their homogenous nature. Subsequent sampling was purposeful, increasingly

reflecting the needs of the study (Glaser, 1978; Bogdan & Biklen, 1982). Informants were selected on the basis of their ability to expand on and enlighten specific areas of interest.

The selection of informants from the Diploma CBT course was in effect random and involved asking for volunteers willing to sacrifice a lunchtime to be interviewed for the research.

3.1.5: Analysis of the research data

Analysis began by open or Level 1 coding (Strauss & Corbin, 1990) naming and ascribing meaning to each line wherever possible in active and specific terms to create *substantive* codes. (Glaser, 1978). The constant comparative method was used to allow the generation of theoretical constructs from the substantive codes. This involved comparison of incident with incident, incident with category and finally category with category (Hutchinson & Wilson, 2001). This process allowed the structure, dimensions and properties of the second level of codes or *categories* to emerge, as well as leaving an audit trail (Rodgers & Cowles, 1993) Memos were kept throughout this process (see appendix), asking questions of the data, recording hunches and assisting with the comparisons and ultimately helping to develop the increasingly conceptual categorisation of the data (Charmaz, 1995).

The third stage of coding involved theoretical sampling (Strauss and Corbin, 1990). Here analysis was more selective as data was sought specifically to develop, test and refine emergent theory.

Finally after basic social processes had emerged, sorting of categories was worked through in an attempt to create a coherent whole or parsimonious set of integrated concepts (Glaser, 1978).

The analysis phase in the research was considered complete once the author felt that *saturation* had been reached i.e. that additional data led to no further development of developed categories/concepts.

There is a full presentation of the grounded theory methodology in the Methods chapter of this thesis.

3.2: Data Management and Transcript Conventions

3.2.1: Data management

The main decision to be made in consideration of a data management protocol for a qualitative study is whether to utilise one of the computer software packages specifically designed for the task or to manually organise the data to allow for retrieval and analysis. Software packages are held sometimes to be advantageous because they speed up the coding process, provide a formal structure for writing and storing memos to develop the analysis, provide a more complex way of comparing relationships within the data and in general aid conceptual and theoretical analysis.

Since the advent of such software many researchers such as Seidel (1991) and Kelle & Laurie (1995) have cautioned that such an approach might distance or alienate the research from their data. In essence many of the reservations, which some researchers hold about the use of computer software, can be reduced to the simple question as to whether or not it is apt to apply a machine to the intricacies, subtleties and uniqueness of human meaning, interaction and understanding. In effect the antithesis of the qualitative/constructivist approach.

I believe however that a distinction should be made between the use of algorithmic procedures such as software to aid the *analysis* of textual data and the opportunities afforded of merely ordering and structuring textual material with the help of database technology to improve the ease and efficiency of the analysis carried out by the researcher.

It is significant that my own decision regarding the choice of data management had through necessity to be made at the start of the six year journey though this research project, when I was a novice researcher, overawed and daunted by the task ahead, and with no experience of handling the large amounts of qualitative data I knew the research would produce. My choice therefore, to adopt a manual *(paper and coloured pens)* approach to the grounded theory analysis and data management as opposed to employing a computer software system such as *Nud*ist* was largely based on an awareness that I needed to become as close as possible to both my research data and the analysis process itself in order that I

might best understand it and not add to the distance I initially felt towards my research topic.

The actual data management approach used for this study was therefore an ad hoc system using hand-written field notes, memos, concept maps and tables, shaped by the knowledge that any system used would have to be harmonious with and facilitate a grounded theory analysis of the research data.

The research material was stored and analysed in a study in my own home, as there were no suitable storage facilities in my workplace and insufficient space to physically carry out the analysis.

Data reduction was achieved through the level 1 or open coding process with the copying of open coding performed on copies of the interview transcripts onto small 6 cm x 3cm cards containing *meaning units*, which could be indexed then organised and manipulated to develop meaningful groupings.

The process of reconstructing the data involved organising these meaning units into numerous charts, tables and concept maps and frequently physically gluing them onto large flipchart sheets which could then be tacked onto the wall of my study for *contemplation*. Although this process was untidy and generated vast amounts of paperwork, which was at times hard to keep track of, it did nevertheless allow me to quite literally immerse myself in the data and develop a very strong physical and spatial representation of the horizontal and vertical relationships between the various data sets.

3.2.2: Transcript conventions

Once the research interviews had been conducted and audiotaped they were immediately copied onto another audiocassette for safety and the tabs were removed to prevent 'taping over'.

The interviews were then transcribed to paper as quickly as possible to maximise sensitivity to the material.

This researcher transcribed all interviews, as there were no funds available for an audio-typist.

The transcripts were typed using double space and leaving 1.5-inch margins on each side in Times New Roman font for clarity and to allow room on the transcript page for line-by-line open coding and memos to be written.

In order to maximise the narrative flow and contextual relevance of the transcript I decided to include my own questions as interviewer in the main body of the transcripts so that they more closely resembled what they were i.e. a conversation.

The participants were allocated an initial e.g. 'K' conforming to a code known only to myself to preserve their anonymity which was followed by a semi-colon (i.e. K:) to indicate when they spoke. Similarly I identified myself in the interview transcript simply as 'Me:'

The interviews were transcribed verbatim including local dialect and resisting any temptation to edit or clean up parts of the conversation which made sense in the original (spoken) context but appeared ungrammatical when transcribed.

Finally each transcript was tagged with an identity code identifying date of recording, date of transcription, the identity code for the participant and the research cohort to which they belonged.

3.3: Research Participants and site selection

3.3.1: The Research participants

The workshops in the main study were advertised internally to all qualified healthcare professionals who were involved in regular, direct clinical work. Attendance was voluntary and no course fee was required. Other than the above-mentioned criteria that all attendees of the workshops required a professional qualification such as registered mental nurse (RMN) or graduate occupational therapist and that they were involved primarily in a clinical role working with patients/clients. Those who attended the workshops were essentially self-selecting in that they were those who responded to the advertisements for training.

Over the four series of workshops, the compositions of each cohort varied significantly. The first was a homogenous group, namely the Primary Care Liaison Team (PCLT). This was a newly formed team of 6 RMNs who had been charged with providing proven, short-term psychological interventions to community-based patients suffering from mild to moderate neurotic disorders.

This group consisted of five females and one male who ranged in age from 25 to 36 years. Five of the group were E grade staff nurses and one was a G grade senior charge nurse who combined overall managerial responsibility for the group with a clinical role. None of the group had any previous formal training in CBT, nor had they attempted to work with patients using the model.

The second cohort was a more mixed group consisting of eight RMNs from a variety of ward, day-care and community settings plus one graduate occupational therapist. The gender ratio was six females to three males and ages ranged from 23 to 45. Again none of the group had any previous CBT training.

The third cohort were the occupational therapists who are discussed as a separate study elsewhere in this thesis

The fourth cohort was again a mixed group, mainly comprising 10 mental health nurses from a variety of settings with the inclusion of one mental health physiotherapist.

The author previously knew all participants in the main study, mainly as colleagues through working in the same institution for a number of years with some additional social contact with some of the participants.

3.3.2: Site selection

The training, which formed the basis for this study, was delivered across two sites, one a psychiatric hospital where the majority of the nursing participants were based and the other a general hospital in the same city, where most of the occupational therapists were based. The locations were essentially chosen for ease of access for the participants. There is a general shortage of good quality rooms which can be used for training purposes within this NHS trust. Accordingly it was a case of trying to book and settle for what was available for six consecutive weeks at a time. This meant that the rooms used for each of the cohorts were different and sometimes the rooms available from week to week varied

3.4: Ethical Considerations

There is a full discussion of the overall ethical stance adopted within the study as whole presented in the design chapter of this thesis. It is necessary here however to provide an account of how specific ethical considerations were managed during the conduct of this study

Prior to commencement of this study approval was sought and obtained from the local research ethics committee of the NHS Tayside, the healthcare trust who were both my own and the research participants employers and on whose premises the study would be conducted

Ethical approval was also sought from and granted by the University of Abertay School of Health and Social Sciences ethics commission.

The need for ethical awareness was evident even before the active research phase of the study commenced. Participants for the study were recruited for each cohort via a series of flyers advertising the training. It was necessary however to distinguish between the training being offered and the research process. It was considered unethical to in any way imply that the training would be provided only to those respondents who were willing to participate in the research. Accordingly, the flyer (see appendix) included an account of how there was a research component to the training but stressed that participation in the research was entirely voluntary and that potential trainees who did not want to participate in the research would not be discriminated against. In an interesting role reversal it is amusing to recall that the original cohort #1 (the PCLT) actually in effect attempted to coerce this researcher by offering to participate in the research in exchange for their participation in the study! I had met with them in a separate context to the research and described in passing the research project I was about to embark on without actually considering them as prospective participants. A few days later they approached me using their willingness to participate in the research as an incentive to me to provide them with the training!

Throughout the writing of this thesis all potentially identifying references to individuals names, jobs or specific locations were removed from the transcripts to protect the anonymity of not only the research participants but also of any colleagues or patients they might have mentioned.

Once I entered the data collection phase of the research it quickly became apparent that many of the participants felt the need to discuss personal issues, which I did not consider to be within the scope or boundaries of this study. Accordingly I developed the custom of turning off the tape recorder at the end of the interview and allowing the participant to continue the discussion into more personal areas without compromising their confidentiality.

Finally, again once the data collection phase of the study began, it became apparent that the issues which the participants were discussing were of often of great emotional significance to them, frequently disclosing their hopes, fears and anxieties in a more open and uncensored manner than I had anticipated. Although I was acutely aware that my relationship with the participants was not that of *therapist and patient* as I was used to in my clinical role, I nevertheless felt that it was appropriate to afford the research participants the same consideration and sensitivity I hoped I had provided to my patients in my clinical role which I had refined over my 22 years mental health nurse and 12 years psychotherapy practice.

3.5: Reliability and Validity

3.5.1: Introduction

This section will describe how the criteria of reliability and validity were addressed in this study. It is necessary first to define these terms, establish why these criteria are important in a qualitative study, what they represent and how typically they might be assessed or judged. This section will also seek to contextualise the occupational therapist study, which is included in this thesis as a separate 'study within a study' as one of the key ways in which the reliability and validity of this study was demonstrated.

3.5.2: Reliability and Validity in Qualitative Research

Murphy & Dingwall (2003) suggest that the hallmark of science is the pursuit of truth and the limitation of error. This is often reduced to the shorthand 'rigour' without which research is "*worthless, becomes fiction, and loses its utility*"

(Morse et al, 2002, p.2). Reliability and validity are commonly held to be the main ways of demonstrating this rigour across the research paradigms.

Reliability describes how far a particular test, procedure or tool, such as a questionnaire, will produce similar results in different circumstances,

assuming nothing else has changed (Roberts et al, 2006). Validity is the extent to which either an instrument or the total study measures or describes what it proclaims to (Polit & Hungler, 1999). Mason (1996) goes on to suggest that the key question concerning the validity of a study should be: "*how well matched is the logic of the method to the kinds of research questions you are asking and the kind of social explanation you are intending to develop?*" (p.147).

These concepts however have their roots in logical positivism where experimental research and the measurement and analysis of causal relationships between variables are the norm (Denzin & Lincoln, 1998). In the qualitative research paradigm under which this study is conducted, because of the fundamental differences in the relative epistemological and ontological positions where truth is no longer considered an absolute and ways of knowing multiple, some researchers (Davies and Dodd, 2002) have suggested that the terms reliability and validity should either be redefined or indeed abandoned completely in favour of alternative means to ensure rigour.

Lincoln & Guba (1985) substituted reliability and validity with the parallel concept of "trustworthiness." This contained four aspects, namely: credibility, transferability, dependability, and confirmability. Within these were specific methodological strategies for demonstrating qualitative rigor, such as the audit trail, member checks when coding, categorizing, or confirming results with participants, peer debriefing, negative case analysis, structural corroboration, and referential material adequacy. Interestingly, something of a schism has developed between researchers in Britain and the United States where unlike their American counterparts British qualitative researchers are far more likely to continue to use the terms reliability and validity to describe indices of rigour in qualitative research. Creswell (1994) however rightly suggests that it is perhaps more important in a research paper to describe what methods were used to assure the study's truthfulness and consistency rather than arguing over the terminology.

3.5.3: Strategies used to enhance reliability and validity within this study

1) Audit Trail:

The audit trail is an accepted means of establishing the consistency of a qualitative study (Guba & Lincoln, 1989) and is in effect the systematic presentation, particularly of the analysis components of research material, which will allow the reader to follow and audit the researchers thinking up to the conclusions of a study. In this study I have included direct evidence of the various stages in the grounded theory analysis within the results and methods chapters of this thesis as well as the appendices, with regular use of direct quotations from the research participants, through examples of memoing, open coding and progressing description of the higher levels of conceptual analysis. There is inevitably a tension between the need for openness/ transparency and sufficient conciseness to render the study readable. Accordingly only key examples of the coding/analysis process have been included in the main corpus of this thesis.

2) The constant comparative method:

The constant comparative method (Glaser & Strauss, 1967) is the dominant principle in the analysis process within a grounded theory methodology and therefore also for this study. In using this method newly gathered data is compared with all the existing conceptual structures such as categories allowing for composition of categories, boundaries of categories and relationships between categories to be established in a cyclical process which only ceases when additional 'new' cases fail to add to the accumulated understanding. The constant comparative method as used in this study confers both external and internal validity. Internally it allows for disconfirming evidence to be considered and utilized to refine developing theory as well as representing the totality of the dataset, providing a strong sense of the relationships, variation and scope that exists within the subject under study. Constant comparison by virtue of its rigour and grounding in the data also confers a degree of *external* validity by providing a solid basis for limited generalization outwith the realm of the study itself, providing there are sufficient similarities of context and subject matter. For example it might be reasonable to suggest that the theory

generated through this study may generalize to studies where different healthcare professionals are undertaking training which also necessitates a stretch outwith the core sense of professional identity or role concept.

3) Triangulation:

The term triangulation is borrowed by social sciences from the fields of surveying and navigation. The principle is that if two points are known then they can be used to plot a third point. In its social science context, triangulation implies combining together more than one set of insights in an investigation as a means of enhancing its validity (Denzin, 1970). These various sets of insights include: **Method triangulation** whereby either different types of the same method (within methods triangulation) or different methods entirely (between methods triangulation) are used to measure or explore the same phenomenon. **Data source triangulation**, which as the name suggests refers to the use of multiple data sources to potentially provide different perspectives on the same topic thus improving validity and finally **Investigator triangulation** where the potential for researcher bias can be reduced. The main form of triangulation used within this study is data source triangulation. (Hammersley & Atkinson, 1996, p.230) define this as: "*The checking of inferences drawn from one set of data sources by collecting data from others...or, as in respondent validation, the accounts of different participants (including the ethnographer) differentially located in the setting.*"

The inclusion of the occupational therapy study as a stand-alone entity within the main thesis is the prime example of the use of this form of triangulation within this study. Here research participants other than nurses attended the same training as their nursing counterparts and were followed-up for study in exactly the same way. The findings from this study within a study were then used as a point of comparison to improve the reliability and truthfulness of this study. Very similar themes emerged across the two conditions and this is discussed in detail in chapters 7 & 8 of this thesis. A second example of data source triangulation used in this study is the inclusion of interview data from four students from the University of Dundee Diploma in Cognitive-Behavioural Therapy course. Although they were also training in CBT, the training was profoundly different in content, depth, duration, location and in its award

bearing status. Nevertheless the findings echoed surprisingly similar themes to the research participants from this study.

4) Respondent involvement:

Another robust means of enhancing the truthfulness and consistency of qualitative research is to again attempt to offset potential researcher bias by involving the research subjects by seeking their views on the accuracy or the research findings (Ashworth, 1993; Holloway & Wheeler, 1996). In this study, this was achieved by using focus groups partly to feedback to the research participants this researcher's understandings garnered from prior individual interviews in effect giving them an opportunity to confirm or refute them. A second way in which this was used was when constructing the semi-structured interview schedule for the cohorts following cohort #1. Findings from the analysis of previous cohorts were incorporated into the schedule and a typical question which might be asked was: "*Other people I've spoken seem to have worried that the patient might somehow try to catch them out, have you experienced this*?"

5) Narrative accounts:

Slevin & Sines (1999) suggest that the presentation of unadulterated narrative accounts in the body of the research report helps to ensure consistent and truthful presentation of the field data. Altheide & Johnson (1994, p.489) caution against the selective presentation of the highlights of field data: "*There is a distinction to be drawn between the interesting, provocative and insightful accounts of ethnographic research and high quality ethnographic work.*"

In this study direct narrative accounts are used throughout the body of this thesis, in the results section and in the audit trail evidenced in the method chapter allowing the reader to check the truthfulness of the findings as described.

6) Reflexive awareness of research reactivity:

Streubert & Carpenter (1999) suggest that researchers who enter the culture which they are researching will almost inevitably change those who are being studied and therefore the culture itself. This response of the researcher and the

research participants to each other is termed "research reactivity". It is necessary therefore for the researcher to be aware of how his/her own values, preconceptions or experiences might influence the conduct and interpretation of the research (Parahoo, 1997; Ashworth, 1997).

Paterson (1994) suggests a *reactivity framework* consisting of five themes designed to minimise the possibility of researcher bias. I will now briefly consider each of those themes and how they were used within this study:

Emotional valence between principals

This is simply the identification of the emotional dimension to the interaction between researcher and research participant i.e. the principals in the study. The reflexive ability to be aware of and then bracket emotional valence is crucial to minimising the influence of the researchers own emotional reactions on the study or at least allowing the reader to assess the influence such factors might have. This was achieved in this study by the recording of personal memos (Strauss & Corbin, 1990), which included an emotional dimension, throughout the research process, examples of which are included in the appendices to this thesis.

Distribution of power between principals

Slevin & Sines (1999) considered it important that respondents did not perceive the researcher to have more status or power than themselves, cautioning that this could have led to responses unconsciously framed in order to meet with the researcher approval. Miller & Glassner (1997) consider that being an insider or having membership of the group can also confer advantages although this has to be balanced against Lipson's (1991) caution that becoming overly close to the research participants can compromise objectivity. A balance therefore has to be struck. This was achieved in this study by treating the participants as experts in their own fields, and adopting an interviewing stance whereby I would encourage them to help me understand from a position of relative ignorance, which particularly in the case of the occupational therapists was very easy to accomplish! With the nursing participants in the study I was able to build on the commonalities of a shared history together on many of the same wards, nursing many of the same patients and so use this to gain insider access to the group.

This was balanced throughout by maintaining a certain degree of academic and professional detachment and maintaining appropriate boundaries. For example I counted one participant as a close friend and was in fact best man at his wedding. For the reasons cited above it was deemed inappropriate to sample his interview for inclusion in the study.

Importance of interaction to the principals

Paterson (1994) suggests that in order to facilitate interaction it is important to maintain attentiveness during the interviews and not appear bored, tired or disinterested. I considered myself to have something of an advantage in this respect in that my clinical role for the last twelve years has been that of a psychotherapist working predominantly in one to one interview situations with patients. Although my orientation is cognitive behavioural, like many colleagues, I consider myself to work within a Rogarian (Rogers, 1967) framework where the therapeutic relationship is given primacy. Accordingly I routinely practice skills such as empathetic understanding and display qualities such as unconditional positive regard, routinely in my interview technique. The participants were put at ease by engaging them in a few minutes of general chat before the tape was switched on and on recently reviewing the actual audiotapes I was surprised at how much actual laughter and humour was present, something which is not always immediately apparent from the interview transcripts.

Goal of interaction

In this theme within Paterson's framework it is considered important to make the aims of the research and hence also the purpose of the interviews explicit to the research participants. Although due to the inductive and emergent nature of the study only a broad outline of the aims of the research was able to be provided at the beginning, the participants were informed that the goals of the research was to develop theory which might provide a framework of understanding for their experiences which in turn might benefit the training of subsequent groups. In the interests of honesty I also explained that I was conducting the study with the goal of obtaining a research degree and that

therefore to an extent my own personal interests were tied up with the research project also.

Effects of normative or cultural criteria

This final theme in Paterson's framework refers to the researcher being aware and sensitive to the norms of value, behaviour and practice of the research participants. Paterson suggests that contravening these norms might evoke a negative emotional reaction in the participants by implying for example criticism or disapproval. Fortunately this was not considered to be major issue given the cultural and historical similarities which I shared with most of the participants, coming from a similar professional, cultural, geographical and ethnic background, and broadly similar age and educational attainment. Again, review of the audiotapes and the easy flow of the conversation captured within, strongly suggests that we shared a common discourse through language and experiences with shared shorthand, understandings and reference points.

3.5.4: Section conclusions

This section has described how reliability and validity might be maximized within a qualitative research study, considered the appropriateness of the terminology to the methodology used and described the various strategies which were actually used during the course of this study.

It was not possible to utilize all the potential strategies available to maximize reliability and validity under the circumstances of this particular study. For example I would have hoped to make more use of investigator triangulation and perhaps been able to persuade someone else with experience of grounded theory to carry out a parallel coding/analysis process of my data. Unfortunately, because I have been working in isolation i.e. not part of a research team or community, this proved impossible although I have been able to gain useful regular feedback and insights from my supervision team. Punch (1998) states that all measures possess some residual bias or unreliability or inaccuracy. Roberts (2006) goes on to suggest that while efforts can be made to minimise such risks, particularly systematic errors, they are acknowledged as a limitation in all types of research. Accordingly then the use of these measures described

above should be read as attempts to minimise bias and error, not to eliminate it. Hopefully however, through the use and inclusion of memos within this study, the reader may be able to better identify biases errors or omissions, which I the researcher have been unable to recognize or bracket myself.

Chapter 4: Methods

4.1: Introduction

In this study grounded theory and action research were the two main methodologies utilised in the research design. In chapter three of this thesis, an in-depth account of the theoretical basis for these methodologies was provided along with an argument of justification for their use within the study.

Both these methodologies are essentially inductive approaches whereby theory is held to emerge from analysis of the research data, in grounded theory through the constant comparative method and in action research through the cycle of observation, reflection, action and planning. This chapter shall therefore primarily provide an account of these two complimentary processes of analysis carried out as a central part of this study, whereby raw data from the interview transcripts was raised to progressively higher conceptual levels of analysis leading ultimately to the generation of theory (the grounded theory analysis) and how the findings from each cohort of research participants were conceptualised and fed back into the next stage of the research (the action research cycle).

Finally this chapter shall provide a description of the delivery of the CBT teaching for the series of workshops central to this study as well as an account of the considerations which influenced the rationale behind the content and style of the teaching.

4.2: Grounded theory analysis

Because the grounded theory analysis for this study was carried out manually without the aid of computer software such as Nvivo or Nud*ist, the volume of paperwork involved in the analysis alone was substantial and therefore it is impractical to present this in its entirety within the body of this thesis. It is nevertheless important for reasons of confirmability to provide an audit trail (Lincoln & Guba, 1985), which might allow the reader to follow the process of analysis. Accordingly one example of the systematic process, which allows a grounded theory category to emerge from the data, is provided in this section.

This includes the raw data, open coding, memos, both personal and analysis, and reconstruction and synthesis products such as transient codes and categories. Because of the need here for clarity of presentation and ease of readability, the memos and analysis notes presented here are not the hand-written originals but have been *transcribed verbatim from these.* Photocopies of a selection of the original notes are included in the appendices to this thesis.

Stage 1: Data Collection.

The data collection throughout this study consisted of a series of audiotaped interviews with either individual participants or focus groups. Once collected onto audiotape, the data was then manually transcribed verbatim onto double spaced A4 paper. The data collection and analysis was carried out exclusively by the author, partly because of pragmatic considerations but also in order to maximise the potential for understanding which occurs when the grounded theorist engages in data collection as well as analysis, affording a greater sensitivity to the more subtle nuances of meaning and process under analysis. (Charmaz, 1995)

Stage 2: Field notes/Reflective diary

As has already been discussed elsewhere in this thesis, the closeness of the researcher to both the research participants and the research data in most grounded theory studies requires that the researcher in some way acknowledge or bracket his/her own subjectivities and emotional reactions throughout the research process (Sheldon, 1998). Accordingly, this researcher kept a reflective diary, effectively combining the function of field notes and personal (as opposed to theoretical) memos.
The example overleaf is taken from the diary entry written immediately after the interview for focus group #1, cohort#1 and prior to commencing open coding.

Example 1:

We're all really trying here, I'm trying to get good meaningful data, trying to stay neutral, not impose...also don't want to seem false (I've been drunk with some of these people over the years!) they're also really trying, they seem to want to reassure me that the teaching's been really good, really helpful, seem grateful, they think ? this research is about me trying to show how effective my teaching is ? they don't want to let me down?

Stage 3: Open coding

Open, or line by line coding, is the first stage in the chain of theory development. The main goal of this stage in the research is to name, categorise and describe the phenomena found in the text.

The example below is taken from Individual interview #1, cohort #1. The open codes are shown above the interview text in red and italicised.

Example 2:

Acknowledgement of lack of confidence *confidence coming with practice*
Its confidence, the last few referrals I've done I've felt much more confident..I've got the diagram out, went through it, even now I'm not that confident, but the more I read

Using a map or plan of the model to help understanding *acknowledging lack of confidence reading more helping confidence*

De jargonising *Giving self time to think about what the patient has told him, putting it down on paper*
it, translate it into laymans speak, I went away and I wrote wee things down, brought

Feeding understanding back to patient *patients more able to relate and accept nurses formulation* *moment of revelation*
it back to them and we went through it and they went "Yeah" once I had examples from real life they accepted it, went "yeah"

using real-life examples

Stage 4: Theoretical memos

These are broadly equivalent to the idea of the 'code notes' suggested by Strauss & Corbin (1990) and were generated as a way of expanding on and conceptualising the open codes as well as asking questions of the nascent theory. Again taking the example of one of the open codes shown in example 2 above:

"Patients more able to relate and accept nurses formulation ... moment of revelation"

The theoretical memo that accompanies that open code, transcribed from the hand-written page notes is:

Example 3:

"That moment when a patient can relate to the verbal formulation is a very powerful moment, anxieties on both sides lessen and communication improves, seems like a breakthrough perhaps?, moves away from dry off-putting theory to having real world relevance. What does this feel like for the nurse?"

These theoretical memos effectively provided a bridge between the first (open) level of coding and the second formal level of coding, namely *axial* coding.

Stage 5: Axial coding

There were two key aspects of the axial coding: Firstly in phase 1 the codes were expanded to consider such dimensions as the phenomenon itself, context, consequences and casual conditions. This allowed phase 2, where the various codes could be compared with each other into a provisional framework of relationships. In example 3 above the process of axial coding allowed the initial code to be expanded into the following dimensions:

Axial coding phase 1: Expansion of codes:

- Phenomenon: The difficulties involved in attempting to apply the CBT training
- Casual Conditions: Patients' inability to relate to CBT model/need to make formulation relevant
- Context: Search for mutual understanding between nurse and patient
- Intervening conditions: Nurses' empathy, insight and willingness to adapt/patients psychological mindedness/strength of relationship
- Action strategies: Perseverance/dejargonizing/using real-life examples
- Consequences: Able to move forward/barriers come down

During the coding process for the first interview (focus group #1 cohort #1) a total of 121 open codes were generated which then went through the process of axial coding with the help of the theoretical memos and were sorted into a total of 28 provisional categories.

Axial coding phase 2: Constant comparison of categories:

A grid was established whereby each of the 28 provisional categories was compared with the other 27. This allowed further clarification of the relationships between the categories and also drew attention to similarities and differences between the categories.

The example given here is of category 13: *Consolidating Learning*

A total of 6 open codes were found to fit with this provisional category including: a) *needing time to think*, b) *making sure they are on solid ground* and c) *recognising the need to refer back to course material.*

A summarizing paragraph was first constructed for each of the categories which was in essence another example of memoing. An extract from the memo relating to the category 13 is given here: " *One prerequisite for this is that they allow for this part of the process therefore overcoming negative feelings (?*

Should this be another category or integrate into "finding a way forward"? They therefore need a safe environment for trying out"

A further paragraph was then devoted to comparisons between categories. Category 13: *Consolidating learning* was for example compared with category 15: *Trying to fit teaching within constraints of service* as follows: "*Before the nurses can consolidate their learning, or as part of the process they have to work out how much time they can give to the patients so that they can adapt the teaching to their own particular situation*"

In comparison with category 16: *seeing the CBT model as relevant*, it was observed: "*As part of the same integration theme as (15) above, the nurses need to come to terms with the fact that the model may only be partially relevant to the particular case and then move forward in that knowledge*"

Stage 6: Theoretical sampling

This process began during the coding of the five individual interviews and remaining focus group subsequent to the first focus group interview and coding process used as the main example above. These subsequent interview transcripts were of course subject to the same coding process and compared at all levels of coding and categorisation using the constant comparative method as described above for the first example. However subsequent sampling of both the research participants and the interview material itself was increasingly purposeful, reflecting the need to refine, develop, illuminate and even reject the provisional categories developed from that first interview. Theoretical sampling is therefore purposive in terms of allowing for better development of theory.

Stage 7: Coding beyond the development of provisional categories in cohort #1/inteview #1 (Impact memos)

Coding of the interview transcripts subsequent to cohort #1/interview #1 followed essentially the same process as described above. As already mentioned sampling became more driven by the needs of theory development and so a process of rejecting and selection of material and research participants considered to be useful and relevant to the development of theory began. A

further difference was that for each of these each subsequent analyses there was an increasing body of extant theory of progressively higher levels of conceptualisation to allow comparison. Accordingly, open coding was no longer conducted from the perspective of a *tabula rasa,* as had been the case for that first interview transcript. Each open code was now compared to previously generated categories. This allowed for greater fit and refinement of these categories but also generated anomalous codes or those which did not appear to fit into existing provisional categories, which in some cases led to new categories being discovered or existing ones renamed and modified to accommodate this new data.

Once open codes and been raised and axial coding carried out leading to provisional categories in each of the subsequent cohorts a series of *impact memos* were generated in order that comparisons might be made between provisional categories raised from one cohort and those raised in subsequent ones, i.e. the memos were designed to answer the question: 'what *impact* does this new information have on the existing category?'

One of the provisional categories from that initial focus group was Category 8: *Being more active.* The following extract is from an impact memo, reflecting on how data from a subsequent interview impacted on that provisional category:

"*Being more active is not an end in itself. It is having the roadmap through increased understanding which allows the nurse to be constructively more active, exploring a specific direction and intervening for a purpose according to a definable rationale. Being more active is probably better defined as being therapeutically more active and is seen by the nurses as being highly desirable and a welcome contrast to previous (? custodial) role.*"

Stage 8: refinement of categories

The culmination of these coding strategies by the time of the conclusion of the analysis of the data from the second cohort of research participants was a grouping of six main categories, each with several related sub-categories. At that point in the analysis I did not believe that a core category had yet emerged which could legitimately be said to provide an over-arching summary of the six

main categories. One such main category *Consolidating and Beginning,* along with two of the six subcategories: is presented here:

Example 4:

CONSOLIDATING AND BEGINNING MAIN CATEGORY.

Consolidating learning:

Several nurses describe needing time and practice after the teaching in order to successfully apply what they have learned into practice. One pre-requisite of this is that they ***allow*** *themselves the time and space to do this and overcome the negative feeling they have about what they* ***should*** *be doing (more, quicker, better) They therefore need a safe environment-(I THINK THIS COULD BE AN IMPORTANT CONCEPT) for trying out the approach. Trying out seems to consist of: initial hypothesis, going away and thinking about it/reading up (this could be called making sure they are on solid ground) coming back to the patient, suggesting things, getting feedback and so on. The feedback from the patient is again very important.*

Beginning to incorporate teaching into practice:

This is a beginning, it is tentative, not fluent or polished and is accompanied by a great many negative feelings. The need for either self-reflection or a member of the peer group (or even a patient!) is crucial here. One nurse points out that in order to do this, they have to have established a reasonably solid relationship with the patient first (making sure they are on solid ground).

The examples shown above represent the conclusion of the grounded theory analysis for the first two cohorts to undergo the teaching and be interviewed for follow-up. Two further cohorts were subsequently included in this study, with the grounded theory analysis being systematically carried out according to the procedures described above. The fact that the final results section reveals significantly different categories to those described above, along with, finally, a core category is a reflection of the ongoing, emergent nature of this grounded theory study.

4.3: The Action research cycle in action

This section will describe how the action research methodology described and justified in chapter 4 of this thesis was actually employed in the conduct of the various phases of this study. Although in the literature the action research process is often referred to as a relatively straightforward cycle of question selection leading to, most commonly although not exclusively, four inter-related stages of planning, action, observation and reflection, this is an ideal, an over-simplification of a process which is often in reality both iterative and often difficult to discern clearly distinct cycles within that process (Waterman et al, 2001).

The action research cycle as carried out within this study is shown overleaf as figure 4, illustrating the additional *reconnaissance* phase as well and also maps the broad study headings onto the stages of the action research cycle.

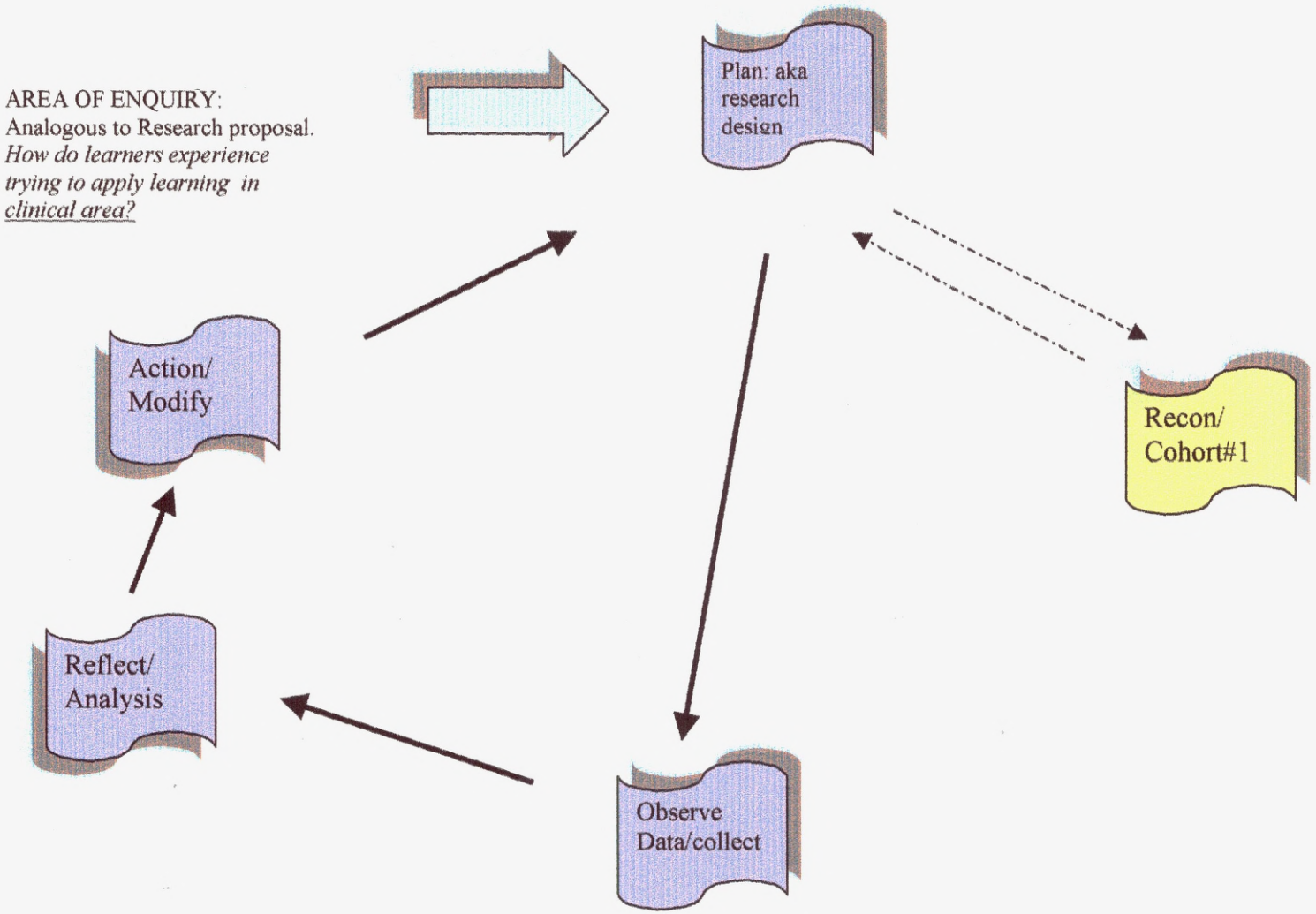


Figure 3: The Action Research Cycle for this study (showing the additional reconnaissance stage)

An action research process typically begins with a question or a broad area of enquiry. The Centre for Outcomes Based Education (Open University, 2005) suggests that: "*action research starts with a question or an observation raised either by you or by your students, about an issue, problem or difficulty experienced by some or all of them in their learning*" (p.8). It has already been established that the other main methodological approach in this study is grounded theory. Like action research, it too begins with a general area of enquiry, rather than a specific research question. Stern (1980, p.20) suggests "*the strongest case for the use of grounded theory is in investigations of relatively unchartered waters, or to gain a fresh perspective in a familiar situation*". It is my assertion therefore that the first stage in this study, which was the research proposal, submitted to the academic institution prior to commencement of the formal research degree, where a general area of interest was highlighted, namely the experiences of nurses attending my in-service-training workshops on CBT in trying to apply their learning in their clinical situations, directly correlates with that first stage in the action research and grounded theory processes where the question "*what is happening here*?" is asked of an aspect of my own existing teaching practice. Since this study is also an academic exercise requiring a thesis to be produced for examination, it was also necessary early in the course of the study to describe and justify a methodology or plan of enquiry, which might provide an answer to, or at least begin to illuminate issues from the identified area of study. The design and methodology sections of both the research proposal and later the actual thesis therefore directly correspond to the first stage proper in the action research cycle namely 'planning'. Those sections describe the 'how' in terms of the proposed method for collecting useful information about the chosen research area.

Interestingly, Lewin (1948) proposed what amounts to an additional stage to the commonly described four stage action research model when he described the likely need for *reconnaissance* in the early stages of the action research cycle, meaning that in order to better understand the area of investigation and to further refine the techniques used to collect and conceptualise the data, preliminary data collection and analysis was required and that as a consequence it might be necessary to consider revision of the overall plan. Waterman et al

(2001) made essentially the same point when suggesting that: "*it is necessary to have some conception of the problem and possible action in order to reflect on and research it effectively* (p.12). This could logically correspond to the notion of a pilot study but equally I believe in an emergent study such as this where theory is built and refined over four distinct cohorts or stages, then it is equally valid to consider the grounded theory analysis of cohort #1 where the research questions were more clearly identified, a beginning of an understanding of the processes involved was gained and the chosen methodologies appeared to be confirmed as being appropriate, as being an example of that same additional phase of reconnaissance in action.

The third stage in the action research cycle for this study was observation. I would assert that the interviewing and data gathering phases of this study directly correspond to formalized forms of the action research concept of observation.

The fourth stage in this action research cycle for this study corresponds to reflection. I have already argued elsewhere in this thesis that the grounded theory analysis of the research data in this study is directly analogous to the concept of reflection in the action research cycle. I have already in this section, suggested that the task of data collection for this study, through interview and memo is in essence simply a highly formalized approach to the action research phase of observation. Likewise I consider that the process of grounded theory analysis might again be legitimately likened to the commonly described action research phase of reflection, but once again a highly formalised and highly structured process of reflection. In most of the grounded theory literature (Carr & Kemmis, 1986; Bryant, 1996) it is stressed that the process of reflection must be a *critical* one. One typical definition of critical thinking is that of Chance (1986) who describes it as: "*...the ability to analyze facts, generate and organize ideas, defend opinions, make comparisons, draw inferences, evaluate arguments and solve problems*" (p.6). Obviously then, the cognitive demands and intellectual discipline required of the researcher who is expected to genuinely critically reflect on his/her research are substantial. I would assert that my use of a grounded theory framework of analysis which, during the critical reflection phase of the action research study provided an effective aid or scaffold which assisted this researcher in remaining authentically critical during the reflection

phase. Indeed the parallels between Chance's definition of critical thinking and the requirements of a grounded theory analysis are striking in their similarity. This use of a scaffold to assist critical refection or thinking already has a precedent in the sphere of educational psychology where, most notably, Steven Coombes (1995, 2000, 2001) who has advocated the use of Information technology (IT) based critical thinking *scaffolds* to facilitate the critically reflective process in action research much as I have used the framework of grounded theory here.

The fifth stage in the action research cycle for this study (I intentionally avoid describing it as the *final* phase due to its ongoing cyclical nature) is the action phase. Stringer (1999) describes this phase as being where the researcher *acts* with the goal of "*resolving issues and problems*" (p.44). This is directly analogous to this researcher's modification of the teaching plans for subsequent cohorts in the light of the theory developed from the analysis of data from cohort #1 in an attempt to better facilitate transfer of training. Figure 4 overleaf is one such modified teaching plan, which was used with the occupational therapy cohort, incorporating modifications based on understandings generated from the combined observation and analysis of cohorts #2 and #3:

Phase 2 OT teaching plan incorporating action research components
Session #2: CBT for depression.

1: Patient referred exercise: Get groups typical experiences of how they normally would approach a patient who had been referred with a depressive illness.
Link this into issues raised in ***identity issues****. Address what changes a CBT approach might require and elicit how the group feels about prospective change, attitudes,* concerns etc.

2: Give handouts, go through model, give verbal example to flesh it out (OK)

3: Brainstorm potential consequences of negative cognitions (OK)

4: Link behavioural symptoms of depression to negative cognitive triad, impact of one on the other. Frame negative thoughts/beliefs as a hypothesis rather than something which the therapist takes a fact. Link this into ***Finding a way forward*** *i.e. strategies which the therapist can employ to take the pressure off in session. Here framing NAT's as a hypothesis rather than a statement of fact which the therapist must then prove shares the burden of understanding a patients problems.*
A ***pragmatic*** *thing to include here would be rehearsing or role-playing how the student might suggest this to the patient.*

5: Introduce prejudice metaphor (OK)

6: Common thinking errors: Describe how we all exhibit these tendencies with the errors varying only in frequency and intensity in the non-clinical population. Use this as a cue to describe common thinking errors in previous groups of students re the application of CBT as a primer to the students re the possibility of ***negative thoughts*** *having an impact on their own experience of applying the CBT training.*

7: Examples of challenges: Role play here, get the students to practice saying the words, getting comfortable with a new repertoire (as in ***FWF****) They play therapist I play patient*

8: Introduce 3/5 and 5/5 column diary keeping (OK)

9: Link activity scheduling to (8:) Again explore ***identity issues*** *here, extending practice, beginning to move away from the tangible and observable to thinking styles. Get groups feelings.*

10: Backward chain NAT's to schema (OK)
11: Do vicious/virtuous circles acetates (OK)

12: Introduce concept of the formulation here give examples. Address common ***negative thoughts*** *from other cohorts here such as*
a) diagnostic
b) imposition of therapists beliefs
c) need for certainty i.e. viewing formulation as fixed, needing to be right.

Fear of leaving oneself open to criticism from the patient, losing professional integrity

Figure 4: Modified Teaching plan.

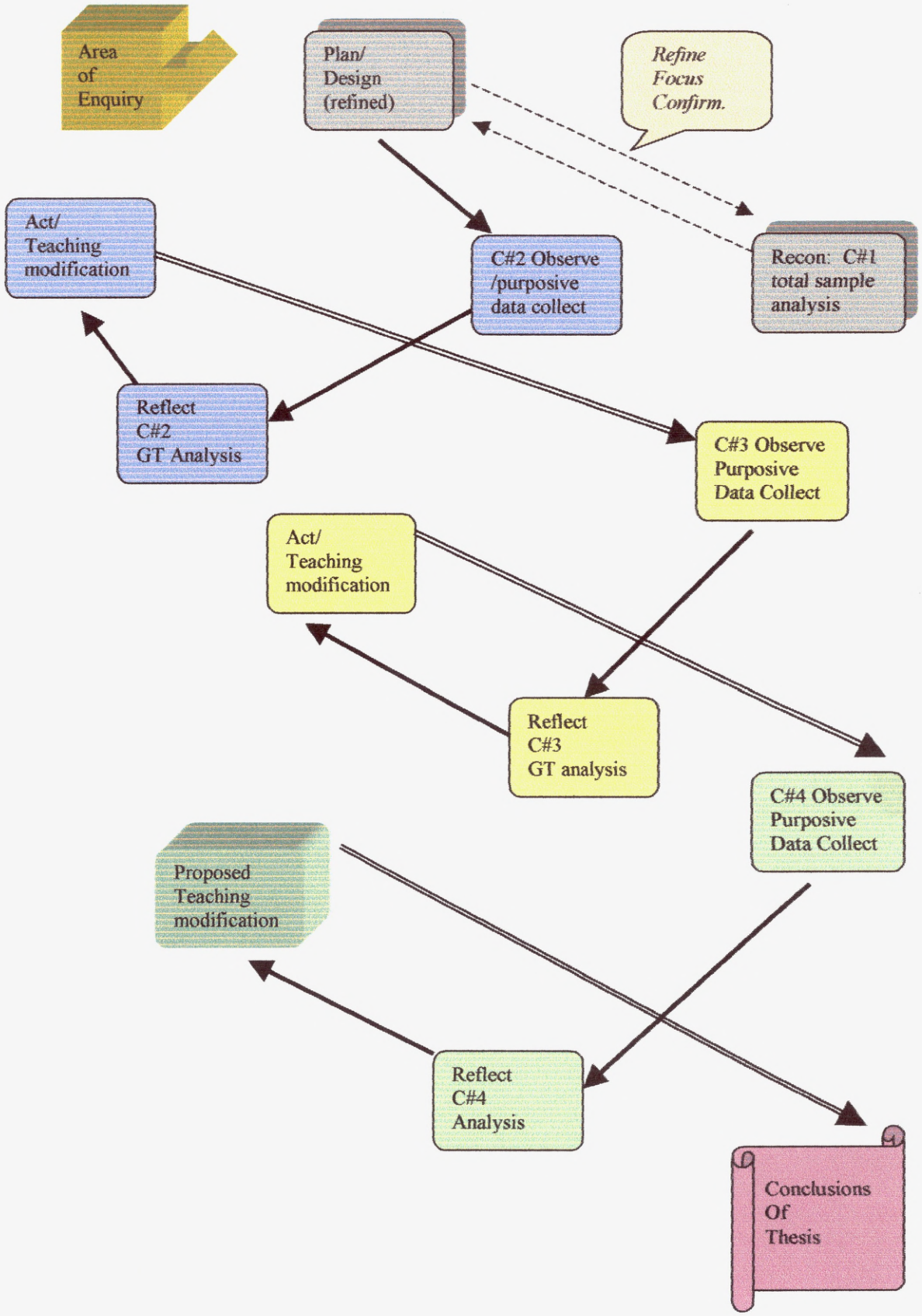
This final stage, stage five of this particular action research cycle, was not the end of a process. On completion of the action phase as described immediately above, the cycle would begin again. Reflection (grounded theory analysis) on observations (interviews) of the impact of the above, modified teaching plan was then used to shape the content of the next teaching plans for subsequent cohorts of learners. McNiff (1988, p.45), reminds one of the *"messiness"* of action research, which rather than a simple circle she shows as often resembling spirals on spirals. Similarly I consider the action research process within this study to be similarly resistant to simple linear conceptualisation. In the above example I in effect, describe one action research cycle per cohort, each leading to greater understanding which is then acted upon in the next. I believe it is perhaps equally apposite to consider the entire study as being ***one*** cycle of the action research process whereby the observation phase consists of the *entire* collection of data (interviews and memos) from the study and likewise the reflection is the culmination of the completed grounded theory analysis presented in the form of the conclusions of this thesis. This second way of conceptualising the action research process for this study naturally then begs the question: *what next*? *How does the cycle continue*? That question is addressed in the *implications for future research* section in the *conclusions* chapter of this thesis.

4.4: Summary of the grounded theory and action research method

In the previous two sections of this chapter I have described how the two main methodologies employed within this study, action research and grounded theory, formed a complimentary framework which effectively mapped and guided the research process. Figure 5 is a diagrammatical summary of the relationships between the structure of the study and those two main methodologies of action research and grounded theory central to its design:

Figure 5: (see over)

Figure 5: Summary of the grounded theory and action research method



4.5: The teaching of the CBT workshops

4.5.1: Introduction to the teaching

The teaching interventions carried out for the purposes of this study consisted of a total of four series of six, half-day workshops, each held weekly. Each series of workshops was held approximately one year apart. Three of the series of workshops were held in the psychiatric hospital where both the learners/research participants and myself were based, as part of an informal in-service training programme. The workshops for cohort #3 the occupational therapists, were held for convenience sake in a nearby general hospital where most of the occupational therapists were based

The content of these workshops was essentially an introduction to cognitive-behavioural therapy (CBT), its theoretical basis and its application to the more common mental disorders for which its efficacy had been empirically established (see chapter 3 for references).

The teaching itself consisted of a mixture of didactic instruction along with opportunities for more informal discussion, case review, role-play and group work. There was no formal assessment or examination and handouts were provided after each workshop. A teaching plan was prepared in advance for each workshop (see below). The author of this study was the sole teacher throughout each series.

4.5.2: Workshop program and teaching plan

A typical program for a series of workshops along with an example of a teaching plan are shown in tables 1 and 2 overleaf:

Table 2: Typical workshop format (Cohort #2)

WEEK 1: Introduction to the model
WEEK 2: Non-specific interpersonal factors (The therapeutic relationship in CBT)
WEEK 3: CBT for the anxiety disorders
WEEK 4: CBT for depression
WEEK 5: CBT for psychosis
WEEK 6: Consolidation

Table 3: Teaching Plan (Cohort #1 session #1)

WORKSHOP#1 INTRODUCTION TO CBT MODEL AIMS: OUTCOMES:	
TOPIC	TEACHING METHOD/LEARNING ACTIVITY.
AIMS AND OBJECTIVES: CONCEPT OF MODELS:	Take pre-screening questionnaires as starting point, collaboratively work out reasonable A and O's with group a) Split class into two groups (5 each). Ask each to come up with a consensus on their understanding of the features of a psychological model. b) Talk class through a case presentation illustrating how the same case can be conceptualised according to 3 different models (cognitive-behavioural, psychodynamic and medical) c) Invite feedback on the classes opinion of models (do they represent a "truth" or do they serve a more pragmatic function?)
INTRODUCTION TO CBT MODEL:	a) Present 'skeleton' of model on flipchart. Split class into teams of two, task to suggest concrete examples for the headings on the model e.g. Behavioural changes: *withdrawal* b) Feedback session, collate results to put flesh on the bones, compare with my pre-prepared example.
HISTORY AND DEVELOPMENT OF MODEL:	Lecture.
Break break break	Break break break break break break break break break
DEFINING CHARACTERISTICS OF CBT: IMPORTANCE OF RELATIONSHIP BUILDING SKILLS:	a) Ask group to brainstorm their impressions of what characterises CBT b) Compare with my acetates focusing purely on the mechanical aspects (short duration, focus on distorted thinking etc) c) Role play a session with volunteer from group (me as therapist, volunteer as patient) overplay challenging/technical/mechanised aspects d) Get feedback from group/volunteer on what was lacking i.e. interpersonal skills/empathy/therapeutic relationship e) Invite group opinion on likely consequences of attempting CBT as in role play
CRITERIA/SUITABILITY FOR CBT	Group exercise. Split into 2 groups. Task: Produce a protocol for suitability/referral criteria for CBT Feedback Comparison to acetate
CASE STUDY	Ask someone in group to volunteer a recent case. Facilitate group discussion re possible formulation as per CBT model *GIVE HANDOUT/READING LIST

4.5.3: Course Objectives

The term learning objective (Tyler, 1949) where the teacher defines a specific behavioural objective, has been criticised by some for being overly teacher based (Eisner, 1979). Given the humanistic philosophy (Rogers, 1969) which underpins most of healthcare education today, the term learning *outcome* is probably more appropriate here, with the focus being on what the student achieves rather than the learning input (Otter, 1992). This philosophy becomes even more relevant given that the learners on this course are adults, colleagues of mine and are actively participating in defining their role within the learning experience.

Despite this course having no examinable component, given that the learning outcomes were essentially skills based, the learners did have the opportunity to demonstrate the skills relating to the outcomes with appropriate feedback during the workshops. These outcomes were:

1. By the end of the course the learner should be able to demonstrate conceptual understanding of the cognitive-behavioural model by providing a written, cognitive-behavioural formulation of a case study addressing a clinical problem specifically not covered in the workshops.
2. By the end of the course the learner should be able to demonstrate their ability to structure a clinical session by collaboratively agreeing an agenda with a patient in a role-playing exercise
3. By the end of the course the learner should be able to demonstrate understanding of treatment options by planning an appropriate graded-exposure programme based on a hypothetical case.

4.5.4: Course Design

In order to ensure the appropriateness of this courses design, there were three key conditions which this researcher attempted to meet:

1. In the UKCC report into the future of nurse education 'Fitness for practice' (UKCC, 1999) the goal of nurse education is described as to produce

"*knowledgeable doers.*" This phrase neatly sums up the need for theoretical knowledge to be expressed as clinical competencies. Informal feedback from the learners prior to the workshops indicated that desire to improve clinical skills was their main priority also. The course design therefore had to aspire to equip the learners with practical, real life skills which might have direct relevance in their clinical environments

2. Clinical practice especially mental health practice involves the practitioner encountering an almost infinite variety of patients and problems, rarely if ever meeting the same situation twice. The course must therefore be designed to equip the learner to function effectively in this unpredictable environment.
3. The learners on this course are all adult learners, bringing with them a vast range of experiences, both professional and private, with them. The course must acknowledge and incorporate these experiences otherwise as Knowles (1988, p.390) states "*When this experience is devalued or ignored by the teacher, this implies a rejection of the person not just the experience.*"

Given these above conditions I attempted to employ an andragogical as opposed to a pedagogical design to the course. The six assumptions of androgony (Quinn, 2000) are as follows:

1. Adults need to know why they must learn something
2. Self-direction
3. Adults have greater experience which serves as a rich resource for learning
4. Adults' readiness relates to the things he/she needs to know and do in real life.
5. Adults have a life-centred orientation involving problem solving and task centred approaches.
6. Adults' motivation is largely internal such as self-esteem, quality of life and job satisfaction.

If one maps these assumptions onto the specific circumstances of this course i.e. a group of health-care professionals, self-selecting by volunteering to attend the course, stating that their main goal is to improve their clinical skills in which ***they*** have identified shortcomings, then the 'fit' is striking.

For the course to meet the challenge of the unpredictability and variety within the research participants' clinical practice then it is necessary to examine the appropriateness of what is being taught and how. My intention was to design the course to equip the learners with an understanding of the *model* and *concepts* of CBT as opposed to expecting them to reproduce a series of rote responses. Northedge & Lane (1997, p.21) suggest that learning should aspire to be "*more about ideas than information, about understanding rather than pure memory*". My hope was that if I achieved this then the learners would be able to adapt what they had learned in the workshops to meet the challenges of novel situations.

Shuell (1986, p.415) states that: "*Cognitive approaches to learning stress that learning is an active, constructive and goal-orientated process that is dependant on the mental activities of the learner.*"

and "*Learning is cumulative in nature; nothing has meaning or is learned in isolation Cognitive conceptions of learning place considerable importance on the role played by prior knowledge.*" This is why there is a strong emphasis on group work in the course where the learners have the opportunity to actively construct understanding.

Comparing the example of the teaching plan given above with the strategies outlined by Linder & Marshall (1996) then a close match can be seen:

- **Concept Mapping**: Throughout the course the CBT model is represented diagrammatically linking relationships between thoughts, feelings, behaviour, life experiences etc.
- **Linking different parts of the course**: All subsequent parts of the course were regularly related back to the initial CBT model presented in the first workshop. The workshop on listening skills and structuring informed all later work on specific disorders. The final "consolidation workshop" pulled together all previous themes.
- **Emphasis on qualitative reasoning**: There were extensive opportunities for discussion both within learner groups and as a whole actively encouraging the process of verbal reasoning

- **Using students in class illustration**: There was frequent role-play throughout the workshops.
- **Linking subject matter with everyday examples**: Use of clinical examples from both my own and the learners work were used in the various case studies.
- **Discouraging note taking**: This was suggested as being inappropriate at the beginning of the workshops

The third test as described above, of the appropriateness of the course, namely the question of whether or not it addresses the theory-practice gap by utilising lessons learned in previous research is of course the issue at the core of this study, with the entire rationale of the research design being to utilise research from earlier workshops to enhance subsequent ones. The initial literature review conducted prior to the teaching and analysis phases of the study revealed a gap in knowledge regarding how CPD events influence change in clinical practice in nursing, with existing research being sparse at best as highlighted in Jordan (1999). The data which does exist suggests that time to practice is an important consideration with Campbell & Gammache (1981) suggesting that education offerings under eight hours could not be expected to bring about change. More relevant however may be Virtanen et al's (2003) assertion that those interventions where the learners identified common learning goals were more likely to bring about behaviour change. Eliciting the learners' goals for the teaching prior to commencement of the workshops, as well as collaboratively setting aims at the start of each workshop went at least partly towards meeting that condition. I was acutely aware however that the biggest likely influence on the issue of bridging the training transfer gap were the research participants' clinical environments more specifically the social systems within those environments and the degree to which they were supportive or antagonistic to their attempts to apply the training (Cervero, 1985).

Chapter 5: Results

5.1: Introduction

This chapter describes the five main categories, including the core category, which were the culmination of the main grounded theory analysis for this study. The cohorts included in this analysis were cohorts #1 #2 and #4 each comprising of mainly nurses. Analysis and discussion of cohort #3, the Occupational Therapy study is included elsewhere in this thesis as an example of triangulation designed to enhance the reliability of this study. The categories are presented here in the form of an introductory paragraph explaining what each category represents, followed by the various subcategories with relevant quotations from the interview transcripts sometimes referred to as 'meaning units' to provide depth and richness to the description and also to afford the reader a direct link from the conceptual level of category to a grounding in the actual research data. The highlighted quotation at the beginning of each category is considered to be an archetype included to sensitise the reader to the overall feel of the category. The manner in which the categories relate to each other and in particular the core category is represented diagrammatically in section 4 of this chapter. This function of this chapter is not to provide a secondary analysis of the conclusions of the grounded theory element of this study, it is instead simply a description of the categories, an account of how they are constructed from the research data and how they relate to the overall study.

5.2: Summary of categories

Category 1 (core): On the threshold

Subcategories:

1: Waiting and looking to begin

1a: Waiting for the right patient

1b: Considering how to sell it

1c: Waiting for the right time

2: Crossing the threshold

2a: Running into problems

2b: Opening up

Category 2: Negative Thinking

Subcategories:

1: Not feeling confident enough

2: Afraid of doing harm through getting it wrong

3: Putting pressure on self

4: Making unfair and unhelpful comparisons between self and others

5: Fear of the patient

6: Finding CBT itself daunting

Category 3: Overcoming Difficulties.

Subcategories:

1: Making CBT more manageable

2: Lowering expectations of self

3: Challenging own thinking

4: Pragmatic, non-psychological strategies

Category 4: Identity and relevance Issues.

Subcategories:

1: Reflecting on boundary issues.

2: Feeling empowered by the CBT

3: Fit

a: Positive fit with role identity/patient needs

b: Negative fit/Role dissonance

Category 5: Understanding and cognitive change

Subcategories:

1: Recognising cues

2: Actively seeking out the model

3: Feeling better able to understand the patient's problems and thinking about them differently

4: Using the understanding to open up therapy

5: Strategies used to improve understanding

5.3: Category 1 (core): On the threshold.

"I've got as far as thinking: I wonder if a CBT approach would help. He had a spasmodic T and walks with his neck like that. I wonder about a CBT approach because I have been eliminating physical factors, I'm going to be left with..."

Subcategories:

1: Waiting and looking to begin

1a: Waiting for the right patient

1b: Considering how to sell it

1c: Waiting for the right time

2: Crossing the threshold

2a: Running into problems

2b: Opening up

5.3.1 Introduction to the category

The data collection phase for each cohort within this study typically lasted up to three months after the teaching had finished. This is a relatively short period of time for follow-up and accordingly this category reflects the research participant's experiences as they find themselves having finished the workshops and now thinking about applying what they have learned in their routine clinical work. The step from practising clinically as they had done prior to the workshops to trying to apply at least some element of the CBT approach to their work, is conceptualised here as a threshold. The research participants in the phase described in this category are variously; a) standing at the threshold, contemplating how they might cross and what the implications of doing so might be b) engaged somehow in actually crossing the threshold or c) have recently began to experience what it is like to have breeched the threshold and begun to apply elements of the CBT approach.

The research participants not surprisingly vary significantly as to where in the process of crossing the threshold they are at the end of the data

collection/sampling phase. Broadly speaking, cohort #1 who were the only group specifically and explicitly charged with providing short-term psychological interventions as part of a newly created team, described more often than did the other cohorts, the experience of actually beginning to apply the approach as per the *opening up* sub-category. Other cohorts more typically described somehow looking for a way in to begin applying the approach, waiting for the right time or the right patient, contemplating how to approach the patient and looking for a match between the patients' problems and what problems they felt the CBT approach might have to offer. This category also encompasses the experiences of the research participants immediately after they breech the threshold for the first time and begin to try to apply the CBT approach. There is evidence of a self-reinforcing positive feedback loop once the participants make the leap, but others appear to struggle. There was a strong sense of an emotional dimension to this category evident in the data. Some clearly felt enthusiastic and excited about starting to work with the approach, others felt anxiety or apprehension. The concept of the threshold and the apprehension of the research participants as they contemplate it is probably most graphically illustrated through the following two quotations:

"I always felt, just launching in, that was always the bit I was, anxiety re taking the plunge, apprehensive about, just the initial explaining it"

The theme of a barrier or threshold which has to be breeched, jumped into or crossed is again referred to in the following quote from a different participant along with further mention of the anxiety associated with the prospect:

"Yeah probably, maybe that's part of the anxiety, I think maybe once I've got my first set of formulations done and done a couple and start doing the treatment, I think it's just taking that jump into it"

5.3.2 Subcategories

5.3.2.1: Looking and waiting to begin

This category, as the name suggests, refers to the stage the research participants find themselves at where they are faced with the prospect of beginning to work with a patient or patients using elements of the CBT model. There is an overall

sense of waiting for the *right* moment where *right* is dependant on several variables such the right time or the right patient. The research participants are actively engaged in a process of trying to match what they have learned from the workshops with the reality of the patient/client populations they routinely work with, looking for a *fit* in terms of patient characteristics and type of problem they exhibit, having been told in the teaching which type of problems CBT has proven efficacy as for depression and anxiety, and also the general characteristics of patients which would tend to indicate their likelihood to engage with a CBT approach such as willingness to accept a psychological formulation of their difficulties. They are also engaged in a process of self-reflection where they consider how best they might guide the patient around to considering engaging in a CBT type approach to their problems.

1a) Waiting for the right patient

As mentioned earlier the research participants have guidelines from the teaching which would allow them to assess which of their patients might benefit from a CBT approach. The two dimensions of this suitability lie in both the individual characteristics of the patient and in the nature of his/her problems.
Likely willingness to participate is one condition which they are looking for in their choice of patients:

"Cos he's be willing to participate, definitely, whereas I can't think of anyone else in here at the moment who would be able to, never mind willing to participate y'know?"

They have clearly taken from the teaching that CBT requires active participation from the patient and are mentally screening out those who they believe will be unwilling to do this. Interestingly, several research participants describe a preference to attempt the CBT approach with patients who are new to their caseloads:

"a lot of the people who are on my caseload have been on my caseload for quite some time, but it's the newer ones that I'd perhaps be more focused with."

In various instances throughout the data they explain this preference by describing how patients get used to the nurse performing a particular role, perhaps simply to listen or to review medication or to provide practical lifting

aids. There is unease and anxiety about then trying after perhaps several months to redefine the basis for the clinical relationship.

Understandably several of the research participants also seem to instinctively search for a patient who has relatively uncomplicated problems where the match between presenting problems and the potential benefits of a CBT approach are more obvious:

"I think actually if I went in and there was something clear-cut, and you could say 'well we'll take this approach' where you could comeback and formalise it"

Often a patient's diagnosis or main presenting problem can be unclear and therefore research participants understandably find it difficult to see how a CBT approach might help. However, when a clear-cut problem such as social phobia emerges from the assessment then it gives them something concrete and tangible to work with:

"I've got somebody here actually who I'm seeing this afternoon, a chap who's got alcohol problems, he's also got social phobia, and I think, I'm kinda keeping my fingers crossed that I'll be able to put more structure, CBT structure when I'm seeing this chap".

The final defining characteristic of a *right* patient appears to be one for whom the participant can identify core components of the CBT model such as dysfunctional thinking, again it gives he or she something specific to address:

"There's one lady at my work and she's absorbed by anxiety at the moment and I'm able to identify with her dysfunctional thinking and how that affects her behaviour...that feels reasonably comfortable...yes"

There is a strong sense in this subsection of caution, and the research participants making sure as far as possible that any attempted CBT approach stands as high a chance of success as possible with minimum risk of any perceived negative consequences to the attempt. This links strongly to the "*negative thinking*" category, which in effect explains *why* they feel the need for such caution. Because they doubt their own abilities, have an exaggerated sense of the need to *get it right* and fear how their patients might react, this caution makes sense from the perspective of the research participants.

1b) Considering how to sell it

The concept of having to sell the CBT approach to the patient is a recurring theme throughout the data. It means trying to help them understand the approach as well as recognising its relevance to their particular problems and in doing so hopefully motivate the patient to engage with the research participant. This is a very new experience for most of the research participants who have tended not to have had to explicitly define what they do for their patients/clients in order to gain the patients active participation:

"it's the fact that you're actually describing it to the patient that makes you more aware of your knowledge level which I think is good because nurses just know, there's nae, we just dae things and we dinnae think about it"

In effect, returning to the metaphor of crossing a threshold, it is not therefore enough for the participant to cross it herself, she has to somehow take the patient with her.

Selling the model to the patient can therefore be viewed as an obstacle to be surmounted, which if not successfully accomplished will cause any attempt to apply a CBT approach to fail before it has started. The main difficulty which this causes for the neophytes, is that in order to describe or sell the CBT approach to a patient they must first themselves have sufficient understanding of the principles and practice of the approach as well as being able to adapt any theoretical understanding to the real-life situation or problems which the patient presents with:

"And you think, "this could fit into the CBT model" and you're sitting there and you're thinking, "how am I going to broach this" and "how am I going to describe it" and that in itself is anxiety provoking"

Again, this subcategory reflects the consequences of the '*negative thinking*' category where fear of *not getting it right* or a negative reaction from the patient can lead to hesitancy, over-caution or outright avoidance of progressing treatment.

1c) Waiting for the right time

Breeching the threshold in this category brings with it potential difficulties and accordingly it can be an anxious time for the research participants. We have already seen that they try to cope with their anxieties by variously trying to ensure that they have worked out the best way to sell the idea to the patient and making sure that the patient has both suitable individual characteristics as well as an appropriate diagnosis prior to attempting a CBT approach. The final condition which the research participants attempt to have in place as part of this understandably cautious approach to beginning, is to ensure as far as possible that the relationship with the patient is as strong as possible before broaching the subject of a CBT approach with them:

"But I think it's more, it really depends on the patient, you really have to know the patient before you decide what, I think you would feel more confident with others than some plus some are more receptive to that kind of work as well"

In the negative thinking category there is strong evidence that they frequently worry about how their patients might react if they suggest attempting a CBT approach, citing concerns that they might become defensive or ask difficult questions of the already uncertain novice therapists. If the research participant can establish a trusting relationship with the patient then this seems to give then a firmer footing from which to launch into relatively uncharted waters:

"I think it is just a case of it really is.. initially you think you've established rapport quite quickly with him, but that trust thing, as I get to know him better and better you're able to start throwing in more words like self-esteem and him not having a role in society, so you can sort of bring them in now"

5.3.2.2: Crossing the threshold

Whereas the previous subcategory dealt essentially with the research participants experiences of preparing to cross the threshold, this second subcategory concerns itself with the experiences which the research participants have once they begun to actually cross the threshold and begin to actively try elements of the CBT approach with their patients. There are two subsections to this category. In the first, *running into problems*, the research participants are

either unable to fully engage with the CBT approach and in effect *get stuck* in the assessment phase of the process, or they overcompensate for their anxieties and try too hard. In the second subsection, *opening up*, there is a positive feedback loop whereby the research participants' efforts are reinforced by the response of their patients allowing them to move forward in the process.

2a) Running into problems

Two of the research participants described making a commitment to beginning a CBT approach with their patients but getting stuck in an early stage of therapy. They both described finding it difficult to progress from the assessment phase of therapy to the more active therapeutic components of the model such as behavioural experiments, thought challenging or even giving a written formulation:

"I'm moving from assessment into treatment, it's been quite difficult for me"

Assessment appears to feel relatively safe for the research participants. It does not involve actually offering an opinion or suggesting a treatment option, both of which appear to be potentially anxiety for some, more often from a nursing background, who are unused to taking the responsibility for planning and initiating treatment. Most nurses are instead more familiar with the more general concept of *care* planning. The step from assessment to active treatment can easily be conceptualised as a *threshold within a threshold,* where anxiety (see the '*negative thinking*' category) and role dissonance (as described in the '*identity and relevance*' category) are again the barriers to progress:

"Well an assessment is so kinda exploring and questioning and getting ideas and treatment, I've started off just doing assessment continuing with exploring"

Much as some research participants appear to hesitate at the threshold of attempting a CBT approach as described in subcategory one, then so it appears do others hesitate or simply get stuck, whilst contemplating the move from assessment into treatment.

A final problem which is described once the research participants take the plunge and attempt CBT for the first time is in effect the opposite of the hesitancy or avoidance as described above, instead some appear to over-

compensate for their anxieties and try to do too much, causing confusion and lessening the effectiveness of therapy:

"I had a really bad session, I was so confused with this woman because of trying to do too much, and where do I start, and at the end of the session she actually gave her first negative feedback and it was 'oh God! That was really confusing'"

2b) Opening up

"The more that you do it, you have a bag of tricks, trying it and seeing that it works is what gives you confidence"

Those research participants who do successfully cross the threshold and begin actively working with their patients using a CBT approach describe a process whereby their efforts tend to be reinforced by the patients' response (it is noteworthy here that the patients actual positive responses tend to far outweigh the feared negative ones). This positive response from the patient appears to dispel many of the negative anxious thoughts which might have held the nurse back and gives them encouragement to progress the approach:

"*the only thing I was going to say was when the patient seems to give you positive feedback, when they're saying to you "yeah this is great" it reinforces the fact that you must be doing something right (okay) and it made it a bit more easy for me then to get more fluid with it*"

Not only does the patients' response boost the confidence of the research participants as seen in the above quotation, but drawing the patient into an active discussion of the nature of the problem also potentially boosts the research participants' own understanding:

"They start opening up and telling you things and you're like throwing things back at them" "I think it makes me more aware, it makes me more aware of what the client is telling me, which in turn lets me then go more in depth"

The response of the patient is crucial to this process and therefore it is important to examine the research participant's descriptions of exactly how and why their patients seem to respond so positively. One factor appears to be that the CBT model offers them a tangible and easily understood conceptualisation of their problems where previously they may have had none:

"I think its actually helped the patient because they've then sat and thought "god you're right enough because I haven't really got any evidence to support what I'm saying" If you know what I mean"

Another part of the opening up process is simply that even if the patient does not actually agree entirely with the formulation which the participant is offering, the very fact that they are being offered some form of cohesive explanation for their problems gives them something to disagree with. This however is not a negative experience because it allows for constructive dialogue and a basis for clarification:

"It's the breakdown of barriers as well cos you're actually explaining what you do (yeah) and you're giving the person an opportunity to challenge this model, what you do whatever, because I think that's a positive thing, its giving the patient the opportunity to, you know cos you're kinda saying "this is what I do"

This mutual creation of understanding which the opening up process facilitates, links directly to the *Understanding* category as described later in this chapter. As illustrated in the overall process model which is shown at the end of this chapter, the greater the understanding the research participant has, the more likely he or she is to attempt to breech the threshold. The reason however that this has been conceptualised as a positive feedback look is that clearly once the barrier is breeched then the CBT framework allows the patient to contribute to and significantly enhance that mutually created understanding and so on.

In the following quotation, providing a formulation, which allows the patient to enter into a meaningful dialogue, is viewed as a way of breaking down barriers between patient and therapist, allowing for an exchange of ideas and opening up the process of therapy:

"Then when you feed it back to them, its like they sit there and think "god you are listening to me, you do realise how I feel" and like you say it breaks the ice they open up much more and feel more comfortable"

The fact that the CBT model encapsulates much of the information given to the therapist by the patient, organised into an easily understood conceptual framework then reflected back to the patient, seems to suggest (as is indeed the case) that the therapist is listening and paying attention to the patient. This clearly has further beneficial effect on the therapeutic relationship and again allows for the development of therapy. The process described here, whereby

once the participant risks failure in breeching the threshold, suggesting a CBT approach or offering a formulation but is then reinforced by the usual positive reaction from the patient, which then gives the participant the confidence to take the approach further can be conceptualised as a positive feedback loop. See figure 6 overleaf:

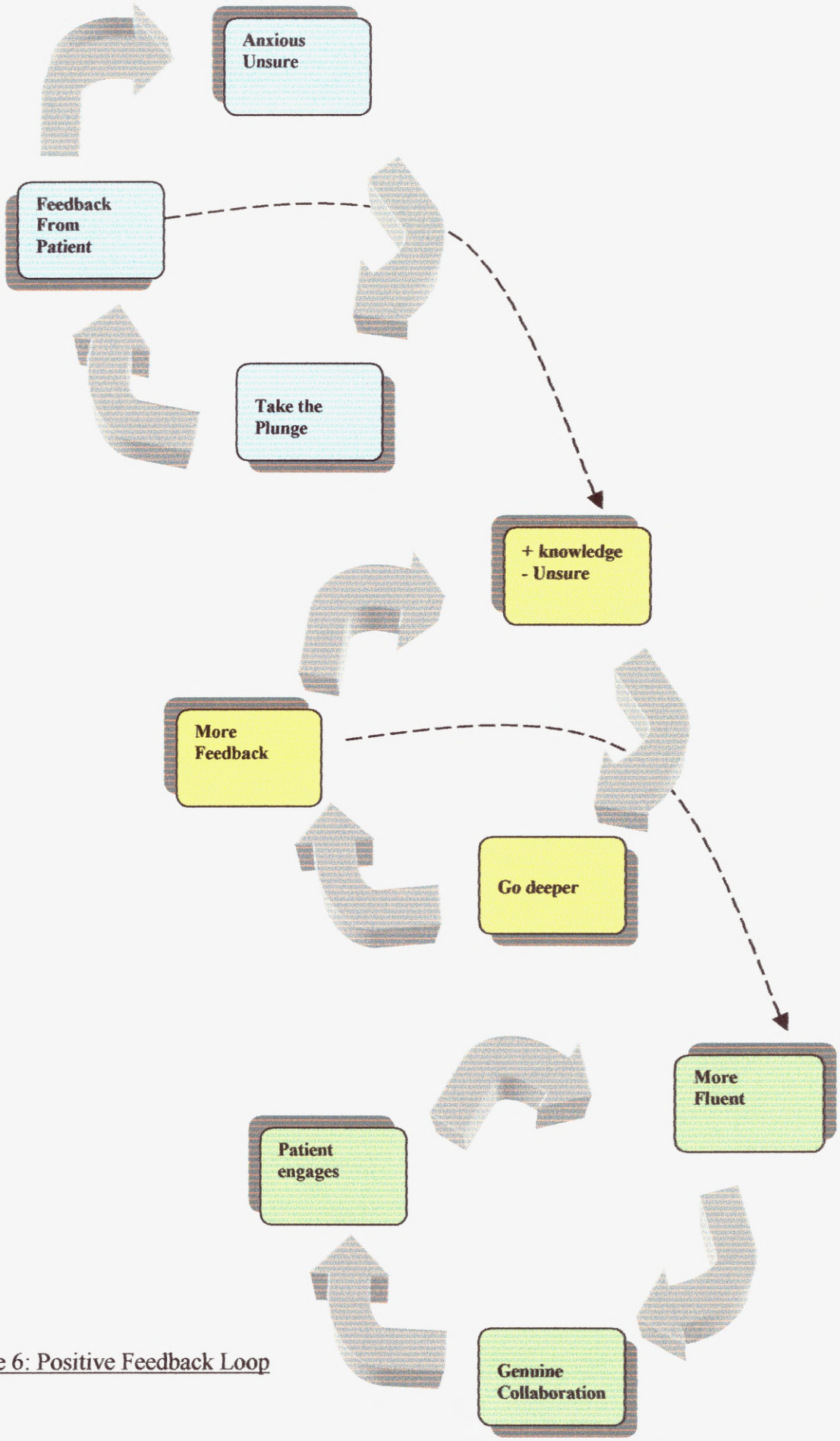


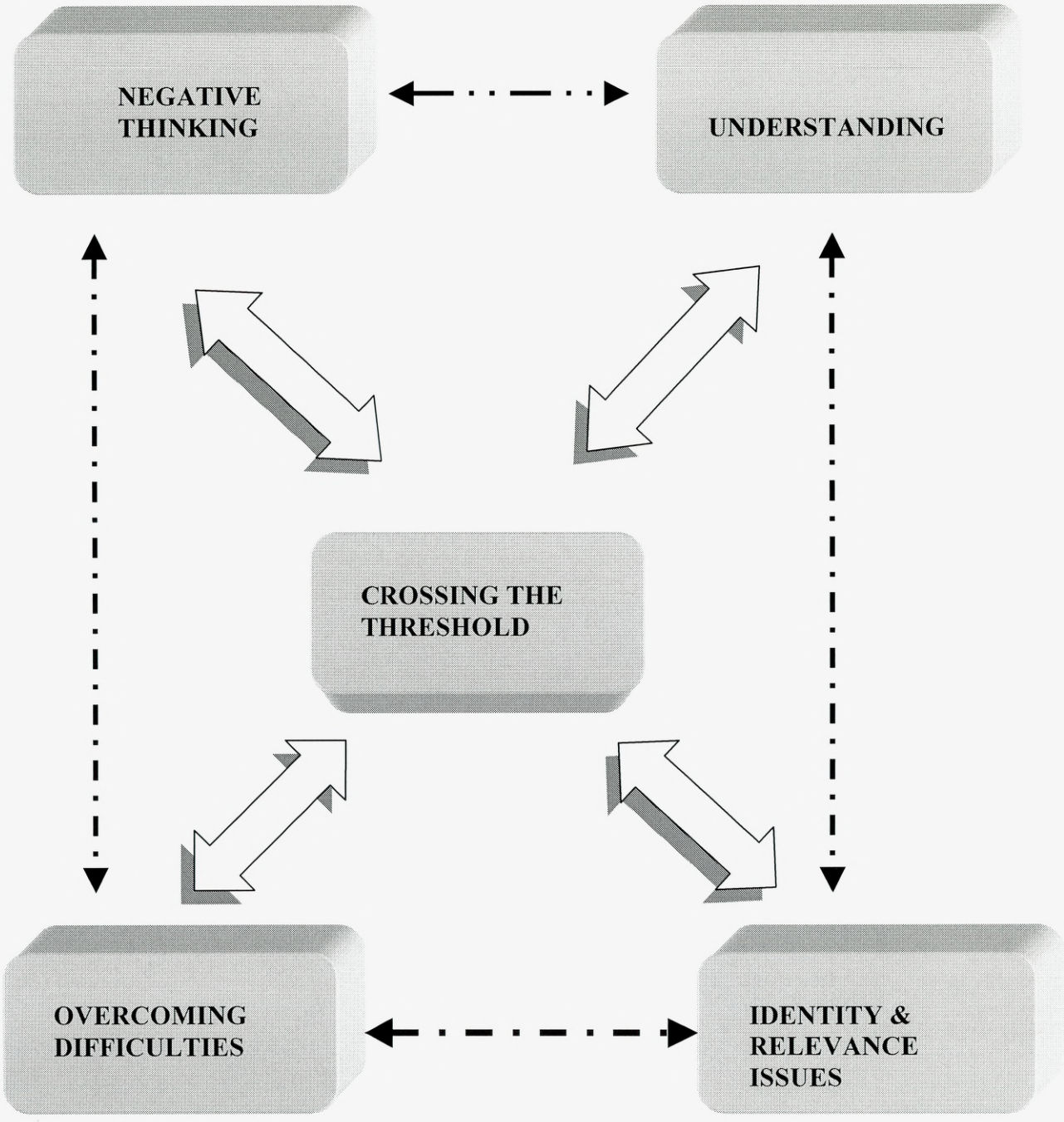
Figure 6: Positive Feedback Loop

One of the key concepts which was stressed during the workshops was the collaborative nature of the CBT approach whereby responsibility for therapy is shared between patient and therapist with each helping the other to make sense of things and come up with treatment solutions. When the research participants adopt this philosophy it again allows the process of therapy to open up:

"What I like is the fact that you're giving the patient responsibility, you're not saying I know everything cos its their thoughts, their feelings and they are actually helping you to find out you know like with diary keeping, that gives me to a better understanding of what's happening (right) to you at this time and it puts the onus right back on them"

This phenomenon relates strongly to the '*overcoming difficulties*' category whereby one of the implicit strategies used by research participants to overcome their anxieties about trying CBT is to challenge their unhelpful thoughts regarding the need to adopt an omnipotent, expert role an assume that it is their responsibility *to do* for the patient. In the above example the participant gives himself permission **not** to know and so draws the patient into a more active role. I consider this category to be the core category for the grounded theory analysis due to the fact that it encompasses most of the themes described in the other categories and provides a central hub within the overall process model (see figure 7 overleaf):

Figure 7: Overall process model



The category is however not simply a repository for meaning units which should instead reside in other categories. The examples given here relate specifically to the concept of the threshold and in particular offer a more dynamic representation of the research participants experiences of approaching and (in some cases) crossing it, along with the vectors which variously propel or inhibit the process, hence their inclusion together in this discrete category.

5.4: Category 2: Negative Thinking

" I say every other day since I've come here and it hasn't been that long, am I doing the right thing? Don't know if I am making these people better, am I making them worse? Who knows if I am saying the right thing? Who knows if I am saying the wrong thing?"

Subcategories:

1: Not feeling confident enough.

2: Afraid of doing harm through getting it wrong.

3: Putting pressure on self.

4: Making unfair and unhelpful comparisons between self and others.

5: Fear of the patient.

6: Finding CBT itself daunting.

5.4.1: Introduction to the category

This category encompasses the research participants' negative psychological reactions to the prospect of applying what they have learned from the CBT workshops to their routine clinical work. It describes how a) their system of beliefs about themselves as nurses b) their predictions of the *demands* of delivering a cognitive behavioural intervention and c) their perceptions of the difficulties in the work environment, would frequently interact creating a negative and ultimately unhelpful emotional reaction based on distorted cognitions with the ultimate behavioural consequence that some delayed, procrastinated in or avoided applying the CBT approach.

It seems reasonable to assume that some degree of self-doubt will accompany most learners' reactions to any CPD event especially where they are then expected to apply new skill in their clinical work, and that this might even be viewed as healthy. This category however covers those reactions, which could be classed as cognitive *distortions* i.e. where the learner either overestimates the demands of the task and/or underestimates his/her own abilities.
This distinction between appropriate recognition of ones limitations after a relatively brief teaching intervention and the more unhelpful, negative style of thinking was checked with the research participants periodically during the

interviews. All showed a high degree of self-awareness, and on questioning about their reactions to the teaching often typically volunteered that they were perhaps "*being hard on ourselves*". Essentially there appeared to be an internal debate going on in their minds where they would attempt to rationalise their self-doubts and anxieties with some demonstrating greater success than others.

5.5.2: Subcategories

5.4.2.1: Not feeling confident enough

The research participants describe a belief that they do not have the skills required to apply what they have learned through the workshops in their clinical work. There is anxiety associated with the belief that they lack the competence to legitimately apply a CBT type approach:

"I know sooner or later I am going to come across somebody that is going to have massive problems and really have a lot of psychological issues, and I am going to think to myself "what do I do here" and that in turn is going to make me feel like a numpty and I haven't got a clue what I'm doing"

5.5.2.2: Afraid of doing harm through getting it wrong

More than simply not feeling confident enough, a significant majority of the research participants reported concerns that as a consequence of their lack of competence they could do more than simply fail to bring about improvement in their patient's conditions. There appeared to be genuine anxiety bordering on fear that they could be responsible for actually causing them harm:

"And another thing that would worry me is that they're very vulnerable at the moment, they're kinda fragile and vulnerable and I wouldn't want to do anything that's going to rock that even worse"

"That something dreadful is going to happen that you're not going to be able to sort out..."

A particular aspect of this concern relates to aspects of the patients' problems which have less to do with here and now difficulties and more to do with issues

from their pasts, traumatic experiences which may form the root of their current problems:

"... I don't think I feel confident enough to get people to discuss their pasts in such great detail, in case issues are going to come up that I wasn't able to resolve or.."

One of the most frequently used metaphors by the research participants to describe what they fear is the '*can of worms*':

"I thought you had to do the course, can't do it, don't touch it 'cos you'll open a big can of worms..."

The can of worms is unresolved issues from a patient's past, which would cause emotional distress:

"I think that's probably my thought, if I do go back, if it's relevant? It probably would be relevant but I would be maybe churning up memories or you know, personal things that would have to come out and surface and is that going to affect my relationship with them and I think all these are thoughts"

The prospect of this emotional distress for the patient is in itself anxiety provoking for the research participants:

"Probably stirring up a hornet's nest, the old Pandora's box, and you let out too much. I mean that would just terrify me"

Not only do the research participants fear opening the can of worms, the also believe that they will be unable to adequately resolve the issues which they have stirred up:

"I don't think I feel confident enough to get people to discuss their pasts in such great detail, in case issues are going to come up that I wasn't able to resolve or.."

5.4.3.3: Putting pressure on self

In this subcategory, the research participants display unrealistic expectations of how believe they *should* be able to perform if they are to utilise a CBT-type approach in their work.

There is a belief at times that they should know everything about the patient and his/her problems:

"there is still that bit that I should know everything"

They describe the belief that all patients for example with an anxiety problem should be able to be helped by their use of a CBT approach:

"..made me feel perhaps I should be dealing with all these people anybody comes up to me and they've got these massive problems, I should be able to deal with them in turn that increased my anxiety.."

In this subcategory the participants have not yet been able to fully internalise the concept of the collaborative relationship as taught in the workshops whereby the patient and therapist *share* the responsibility for therapy:

"I'm just struggling a bit at the moment with the well it's collaborative, as much has to come from the client yet at the same time you're the therapist so you have to be kinda, it's that concept I'm not just quite got a grip on yet"

One aspect of therapy in particular, which features strongly in this subcategory is the formulation. This is simply the therapist providing a provisional written account of the patients' presenting problems, maintaining factors, key developmental issues etc in a CBT framework. In the teaching I stress that this is in effect a tool, a way of drawing the patient into active collaboration, giving them something to critique or disagree with which can then be revised and elaborated on over time. For many of the research participants however it is a daunting prospect as they cling to the notion that anything in writing has to be entirely correct and comprehensive from the outset:

"yeah maybe it is that, 'cos that's a very formal, (a formulation) well it's official and it's there and it's in black and white, and it's something that the patient/clients gonna see, so it has to be very very accurate and precise, very well... there has to be good knowledge behind it"

5.4.3.4: Making unfair and unhelpful comparisons between self and others

I was genuinely surprised when several of the research participants made statements which appear to significantly devalue themselves at the expense of other professionals such as CBT therapists or psychologists who they saw has being more skilled and almost on a pedestal of professionalism:

"when you know little about it you just think 'Oh, the CBT therapists, with the big, on the hill, up there..."

"Slightly, I'm kinda muddling through at this one at the moment I think with a professional like yourself you would be able to"

The *professionals* are believed to always get therapy *right* and usually first time!

"I think because you' re professionals and you are doing it all the time, you would be able to come up with the right intervention etc"

The research participants seem to have a mental phantasy of how the *professionals* perform in therapy:

"I have had the chance to sit in on one session with my supervisor and that was really good, nothing magical happened, there was nothing fantastic, you just work through it"

5.4.3.5: Fear of the patient

Many of the research participants described various instances where they feared that their perceived lack of ability might prove disappointing to the patients they worked with when their shortcomings were exposed:

"As I say, as soon as she, 'cos I think probably her expectations were quite high and as I say that just kinda freaked me out..."

They appear to be aware of a sense of neediness from the patients and fear that they will be unable to meet those needs:

"*at times it can be daunting because you're thinking 'hmm.. what can I do to help this person?' or you somebody who is very complex and they're desperate and they're looking to you*"

A frequent concern was that the patient would either challenge or disagree with their opinion or formulation:

"The fear of the patient saying 'well where's your reference for that? Am I sure this is right, it's a fear of being challenged, being shown wanting because you don't have the confidence or the evidence behind it or rather your interpretation.."

There is a strong link here with a theme which emerges in the identity and relevance category which describes how the nurses in particular are unused to voicing clinical opinions, and suggesting explicit treatment modalities to

patients. The anxiety described in this subcategory appears to be a manifestation of that role dissonance.

5.4.3.6: Finding CBT itself daunting

As well as being anxious about not being able to compete with omnipotent psychotherapists, not coming up to their own, self-imposed standards and disappointing the expectant patients, the research participants also describe an anxiety regarding the challenges of CBT itself. In the *overcoming difficulties* category one of the most favoured strategies employed to overcome these anxieties and shrink the magnitude of the threshold which they faced, was simply not to refer to what they were trying to do as CBT:

"Kinda picking up that there's something scary about formalizing it and saying "this is CBT?" That's probably it, yeah, having a proper structure and making it like actually calling it CBT"

Again due to role dissonance, the prospect of naming what they do as "CBT" is uncomfortable for many of the research participants (this phenomenon is particularly prevalent in the occupational therapist study described in chapter 7 of this thesis). If they claim to be offering a CBT or even a 'CBT-type' approach, then this seems to cause them to believe that they are attempting to practice something which they have no legitimate claim to be doing in terms of qualifications, knowledge or experience.

"And to be honest in some way's I almost feel it's like doing a disservice to the patient to say we will to do work with, based on CBT"

"Don't know if I would actually say I'll do CBT with that patient because I'm not a CBT therapist but I would say I could work, I could assess them etc"

There is also evidence that CBT is seen to be a highly formal, highly structured approach where there is but one *right* way of doing it:

"I think to me the other idea of CBT is you have a definite idea of what you're going to be doing every week in each session, it's structured and that's what you're going to be doing"

As a consequence some were rather dismissive of any attempts which they might make to use CBT in their own work:

"I wanted this lady to get started on proper CBT but for me I didn't want to dabble in it"

5.5: Category 3: Overcoming Difficulties

" I think it's just me getting comfortable with myself"

Subcategories:

1: Making CBT more manageable.

2: Lowering expectations of self.

3: Challenging own thinking.

4: Pragmatic, non-psychological strategies.

5.5.1: Introduction to the category

In the category 'negative thinking' the research participants were seen to struggle with anxieties and self-doubts. Here, the strategies, which they used to minimise, overcome or cope with the negative thinking and so help themselves to continue their development as novice therapists are described.

These strategies comprised in the main a series of psychological adjustments. Essentially what they did was find various ways of lessening the dissonance between their unfairly modest opinion of themselves, their abilities to provide a CBT approach and their at times exaggerated perception of the demands involved with such an approach.

For the most part they displayed good self-awareness of the unhelpful underlying assumptions that generated the dissonance. Through both private reflection and peer support they attempted to modify these assumptions to in effect, give themselves less of a mountain to climb.

Two obvious sub-categories of adjustments suggested themselves from the data: Firstly the research participants tried to make CBT itself more manageable, taking it down from its pedestal, breaking it down into more manageable 'chunks' and stripping it of some of its perceived pretensions. Secondly they engaged in a process of moderating and reappraising their expectations of themselves, in effect attempting to adopt a more forgiving less self-critical internal dialogue.

Finally they adopted a variety of more practical non-psychological measures to address some of the problems which they encountered.

5.5.2: Subcategories

5.5.2.1: Making CBT more manageable

As evidenced in the *'Negative Thinking'* category, many of the learners found the language used in CBT rather daunting. Talk of 'formulations' and 'dysfunctional schemata' seemed to imply a rarefied world of abstractions, academic concepts and intellectualisations. Not only did they feel unworthy of entering that world themselves but they also predicted that patients would find such talk irrelevant to their own more down to earth concerns as well as quickly realising that the therapist themselves was something of an impostor.

Many of the learners not only shied away from using 'technical' language with their patients, but also tended to frame their own understanding of the contact they had with patients in terms other than 'doing CBT'. It felt as if by doing this they avoided the burden of expectation that came with such a claim:

"You know, to say 'this is what I'm doing, a CBT approach and this is why, when and what we'll do, whereas I'll probably do more of that approach without actually naming it"

The use of the phrase "*wee story*" as a substitute for 'formulation' in the following quotation is another good example of the research participants' careful use of language:

"and the wee story, I haven't actually done that yet, (Me: the wee story?) the formulation, which to me is like a wee story which I would find quite useful if it's done informally, for them to sort of look at. So I have been using some of the CBT"

Again the participant in this example is keen to avoid admitting to trying to provide a formulation:

"I don't know if I'm going to do a formulation initially but I'm gonna write down in each area what I think the difficulties with this individual are, and then I'll kinda be able to give examples when I go and explain it to her"

The irony in this case is that she is in effect describing exactly what a formulation entails, but it is easier not to name it so.

Another describes using examples from her own history in a very informal, quite personal way to make the approach seem less daunting for both herself and the patient:

"also I quite often tell them a wee story about when I first started..... so I usually tell a wee story to them to say well I didn't know what it was so aha I do talk about that but then define what it is"

There are in fact several other examples in the data where different research participants use the term "wee" when describing their efforts to try to introduce a patient to the CBT approach. It is hard to see this as being anything else but compelling evidence of their attempts to *shrink* the perceived magnitude of CBT.

Another strategy used innately by many of the research participants when attempting a CBT approach with a patient is to break down the CBT model of therapy into its components, or to attempt to apply only part of the model:

"Well it would be easier just to do the thoughts feelings and behaviour, much easier, easier to sell, to show the cycle"

"I'd take it a lot slower, build up a relationship with them first then say to them...just bring it in bits and pieces"

The research data suggests that this selectivity strongly favours what might be termed the bottom end of the model (see figure 3) namely the vicious circle between thoughts feelings and behaviour which the research participants almost universally feel more comfortable with in comparison to the more conceptual, past orientated parts of the model such as schemata, triggering events and formative events.

Some however despite employing this strategy still worry that they are not carrying out CBT as it should be:

"I haven't done it with her but I basically just told her the bit at the end, the negative thoughts, how that affects the negative symptoms. I suppose to do it properly you have to go through all the steps of the model, don't you?"

5.5.2.2: Lowering expectations of self

For many of the research participants, these initial attempts at trying a CBT approach was their first experience of being directly therapeutically responsible for change in a patient. They also described a common phantasy whereby CBT specialists were seen as being rather omnipotent creatures who knew just what to do every time. Accordingly they tended to set unhelpfully high expectations of themselves. A commonly employed strategy to allow them to progress with a CBT approach was to shrink the magnitude of these expectations from both themselves and what they believed the patients' expectations of them were:

"I'm not afraid to say to a patient, and I say it all the time 'I'm no expert' 'we're going to have to try to work through this together to come up with possible solutions that may help you"

"Well yes I think I might, I'm getting a wee bit better at that maybe, I think when I started I'm getting less, I think I'm getting to expect less of myself and be a wee bit more collaborative."

A large part of this involved appropriately shifting the weight of responsibility for progress back to an equal loading with the patient.

Other strategies under the same heading involved the research participants giving themselves permission not to know or allow themselves time to think and reflect:

"I think that's a big part, you don't, I now feel that I'm not afraid to ask If I don't know something"

"Its going away, I tend to go I will see you next week and have a think about where we are going to go"

One of the reasons highlighted in the negative thinking category which might partly explain where this pressure to perform came from lies in the fear of the patient subcategory where they typically describe anxieties that they will not live up to the patients' expectations. Accordingly then, one strategy, which is often used to good effect is to renegotiate the boundaries of responsibility with their patients:

" 'cos again as well you're saying to them you're no expert, you're here and you can advise them and you can give them different things to do but really it's them that's going to get themselves better. And I think again it's maybe just getting the experience to say that to them"

5.5.2.3: Challenging own thinking

As mentioned previously, many of the research participants show evidence in the research data of being acutely aware that their thinking style, the rules and expectations which they apply to themselves are unhelpful and unfair.

"I suppose, there's nothing in it really I couldn't do, that we're hyper-critical of themselves, I know that personally I am hypercritical of myself, all the time"

In this subcategory there is evidence that many are engaged in a process of actively challenging these thoughts and assumptions, in effect carrying out informal CBT on themselves:

"Yeah I remember from the things that you were saying in the study days, that basically I'd taken on the patient role, and I'm assuming what the patient's responses would be and there's no evidence for this at all"

"I know, I was just thinking about that thinking 'what would happen but probably nothing but, because it's... it's an unrealistic fear I suppose"

For some, the process of challenging their thinking appears more like an argument with themselves:

"It does, it feels right 'cos well why should I come away with all these worries in my head thinking ' this is all down to me, I've got to make the changes here?' That's' not fair!"

A crucial realisation for many of the research participants is that some patients for various reasons will not engage in treatment despite the best efforts of the therapist, novice or otherwise:

"I've not been out in community for long, worked in wards for so long, when people are in the ward they're there no choice, I think they are a wee bit unsure I think we are starting to accept some clients wont engage"

Similarly some appear to be mentally beginning to come to terms with the fact that they are not omnipotent:

"I suppose if I can make the assessment of can I or can't I, I am able to help that person, cos if I can identify when that person is too difficult for me then I am helping them because I am moving them on"

In that above example the participant is reframing his definition of success and failure, accepting that there are some patients he will inevitably be unable to help and referring to another agency or service is actually useful rather than being indicative of failure.

5.5.2.4: Pragmatic, non-psychological strategies

In this final sub-category the research participants described more practical strategies they discovered which facilitated the process of delivering a CBT approach.
These strategies included:

Using examples the patient had provided to illustrate the nature of the CBT approach. This seemed to greatly enhance patient understanding and so boosted the therapists' confidence understanding as opposed to attempts to describe the CBT approach 'cold' using standard examples:

"Other skills I've used that you've taught are use their examples "you said this etc""

Frequently the research participants use another strategy whereby rather than them attempting to broach the subject of a CBT type formulation of the patients problems directly, they wait until the patient themselves begins to touch on issues such as thoughts or feelings and use this as a less threatening way in, having in effect already been invited by the patient:

"but what I do is I when they start to talk about their attitudes and all the rest of it, I can then identify within the model and explain to them about this vicious circle and what I can see happening"

When some of the research participants felt unable to come up with a basic formulation of the patients problems in session or be able to fit what they were hearing into a CBT framework they effectively relieved the pressure they felt by giving themselves permission to develop better understanding in-between sessions, using text books, written notes or even just reflecting on things in

private rather than expecting themselves to come up with the answers there and then:

"I'm just going to get the facts then with the patient make your decision, maybe not there and then maybe a few weeks down the line, as opposed to before you'd go in and think, I've got to cure this person"

"cos I don't think that I'm confident enough to sit there and say "right this is how you are, this is how I see it, this is what you're saying (Yeah) I prefer to go away and think about it first and then come back to the patient"

Many found the use of written aids, particularly in the form of a diagrammatic representation of the model useful to help their own understanding and therefore their ability to successfully describe the CBT model to their patients:

"I've actually been writing out more of a hypothesis its more of a (Me: formulation?) yes, my perception of the patient's problems and where they come from and as well as allowing the GP to be aware its allowing me to be able to crystallise it on a bit of paper and say "yeah! That's right"

Note here again the research participant's dogged determination ***not*** to admit to trying an actual formulation!

A final strategy which the research participants appeared to discovered through trial and error which made trying the CBT approach much easier was to both attempt to keep a tight focus on the session content but also to introduce the CBT approach from the outset of contact with the patient:

"It's just being more focused, that's what I feel the CBT's always telling me is to be more focused to the problems at hand"

"Maybe if you were using that approach though they would know what was expected in a session, (H: and again that's formalising it isn't it?)
(Me: So it would be easier if you kinda started off that way?)
H: yeah!"

This clearly relates to the phenomenon described in the core "On the Threshold" category where research participants described it being much easier to attempt CBT with new patients who had not built up expectations of the role they would typically adopt in session.

5.6: Category 4: Identity and relevance issues.

"I think one of the barriers I felt, ask a nurse, 'what is it that you do?' when you're sitting face to face with patients and nurses cannot answer that, they say 'I talk to them' You cannae pin a nurse down to say 'well this is the model that I use."

Subcategories:

1: Reflecting on boundary issues.

2: Feeling empowered by the CBT.

3: Fit.

a: Positive fit with role identity/patient needs:

b: Negative fit/Role dissonance

5.6.1: Introduction to the category

This is a broad category which encompasses several related themes around how the CBT training impacts on the research participants' sense of professional identity.

For all those interviewed, the prospect of beginning to work with patients or clients using a structured, clearly defined, psychological approach was novel. It represented for some an extension or development of their existing professional identity, whilst others found it to be a complete sea change, in effect they were faced with a clinical role completely unlike anything they had experienced before.

All those interviewed for the study had practiced for at least five years following their basic professional qualification, most for significantly longer, and so had had time to develop a fairly coherent sense of professional identity. Attending the CBT training and contemplating the application of that training appeared to create varying degrees of dissonance depending on how closely (or otherwise) they believed this new development of their role fitted with their pre-existing sense of identity. Not surprisingly perhaps, this varied greatly among the research participants. The group who perhaps experienced this dissonance the most were those nurses who had spent the bulk of their careers working on hospital wards dominated by the medical model. For them, taking therapeutic as

opposed to custodial responsibility for patients was the biggest change to contemplate. For others, such as the occupational therapists interviewed, the shift in focus from tangibles such as behaviour or activity levels to less concrete concepts such as emotions or thinking styles was the biggest challenge.

This chance for development of their roles through CBT was greeted very positively by all of the research participants interviewed. Being exposed to a new way of working caused most of the subjects to reflect back on their careers so far and offer up accounts of what they perceived to be the major shortcomings present in the prevailing ethos of clinical areas they had worked previously (or for some continued to do so). Many had long recognised unmet needs or had experienced frustrations at the limitations of their roles and found now having a pragmatic and explicit framework for working psychologically with patients to be a positive and liberating experience. Others experienced anxious feelings created by unresolved dissonance between their core professional identity and the challenges of integrating a CBT approach into their routine clinical practice.

5.6.2 Subcategories

5.6.2.1: Reflecting on boundary issues

Analysis of the research data showed a consistent tendency for the research participants to spend significant amounts of time reflecting on boundary issues relating to their normal clinical practice as nurses or in the separate study, occupational therapists. I believe that this was because the training or perhaps more accurately the prospect of *applying* that training, actually brought them to a boundary, a limit of usual practice where there were forced to consider the often unspoken norms of professional boundaries. This manifested itself in both contemplation of traditional role boundaries for themselves as individuals and also for their profession, as well as consideration of the implications of change where change was taken to be adopting a CBT element to practice. In essence they described facing the prospect of stepping out of a situation where although there may have been long standing dissatisfactions with the role:

"Before on the wards you would come across patients you knew had issues that they wanted to talk about but didn't feel ready to or nobody was encouraging them to it was a case of let them go away and eventually they will be discharged"

that role was nonetheless familiar, clearly defined and therefore safe.

"I mean as a physio I know my core skill areas, I know what my boundaries are but a physio working with mental health, your boundaries become that bit wider and less defined"

Frequently the research participants reflected quite critically on the perceived role boundaries:

"I think it is a nursey thing, I think it's the way we were trained way back, maybe it's just mindset, 'I'm here to make things better"

Dissatisfaction with the limited roles which they had come to accept was evident along with a certain resentment of other professions for *poaching* the more therapeutically active parts of the job:

" I suppose it's like the borderlines between your job, nurse/therapist/OT you know, all these different things, you know, the traditional borderlines, I think that's where it comes from, the nurse does nursey things and that doesn't include being a therapist"

"mm hmm, like sort of boundaries, but I don't see that as their boundary, I see that as my boundary, that's my work, that's what I want to be doing"

The consequence of this phenomenon was often frustration and disillusionment with the role:

"Oh yeah! Absolutely, I feel quite frustrated at times at my job, I don't get the same satisfaction, from my work that I used to get I just feel, not that I'm ineffective, but just that I would like to be more effective"

"We're that caught up with this bit of paper and that bit of paper and you just think 'we're not really doing our job' not what I envisaged when I qualified, that bright young woman who's going to take on the world, over the years it's just gone out of me"

Typically the nurses would describe a process of socialisation into this role/identity:

"Before you let them say their piece and don't challenge. You just stepped into this environment and everybody else was doing it and it was frowned upon if you stepped out of line, and it's still like that"

At various times during the data sampling reference was made to particular anxieties the research participants experienced when providing or contemplating providing their patients with a written CBT formulation as they had been taught. The following quotation offers a possible explanation for this in terms of boundary issues and identity:

"It's a similar sort of thing to say the problem with the CPNs making a diagnosis on the pink forms and nurses are not allowed to make diagnosis that's what doctors do and there was a lot of argument about that and so yes its probably to do with not wishing to suggest that I have the abilities to make a formulation"

In essence she is explaining that nurses have long been told that diagnosing is not part of their remit. Although the CBT formulation is clearly not a diagnosis, it is more an account of the patient's problems, the likely origins/maintaining factors and possible treatment options, for some of the participants it seems to them to be broadly analogous to one and therefore triggers role dissonance which their instinct is to minimise by avoiding the cause of the dissonance i.e. not giving the formulation.

5.6.2.2: Feeling empowered by the CBT

"Empowering, that's the only way to describe it, it makes me feel good from the point of view, I feel I can help somebody, and you get the feeling when somebody is improving, 'This is me doing this' However much you're saying to the patient 'yeah this is you doing it' I'm thinking 'yeah but it's me that came up with the idea!"

The CBT training appeared to be very much a double-edged sword. On the one hand as described in the precious subcategory, it created a certain amount of dissonance regarding role identity, there was however also a lot of very positive feedback about the training in terms of the research participants considering viewing the CBT training as empowering. Some felt that it allowed them to meet the demands of their job better, some framed it in terms of a close match

between patient needs and what CBT had to offer whilst others expressed a more personal belief that it enhanced their own self-esteem as healthcare professional using such adjectives as "*liberating*".

"And it's the whole ethos of patient participation, I like that, because that's what we should be doing (Yeah!) and it's this getting them to do thing"

The nurses in the main body of the study described how having the ability to conceptualise patients' problems in a cognitive behavioural framework, which then suggested a focus for treatment that they themselves could offer was, for most, a novel and positive experience. They described how they now felt they had something of worth to offer patients and consequently that they themselves as nurses had some intrinsic therapeutic worth. The ability to be "active" and "challenging" was highly valued and clearly in contrast to how they viewed some previous clinical roles:

"but I also find it enjoyable when you can challenge the patient, because that to me is a new, that's a new format for me (okay) cos in the wards and things you're not allowed to really challenge the patient"

Being able to now define their role and therapeutic approach particularly to the patients they were working with was also highly valued:

"I feel that the CBT workshops allow me, give me a better understanding to make that link and when I did feed it back to her and say do think this might be the reason why, and the vicious circle, it all just seemed to click, and it gives you a nice feeling"

In addition they also now seemed to feel that they had a more clearly defined role or function within the mental health services. Many described a sense of confusion and uncertainty about just what the traditional nursing role might be with a conflict of confusing, hard to define ideologies and models being bandied about within the profession:

"we just dae things and we dinnae think about it (yeah) and I think sometimes that's quite a dangerous practise but this you're looking at it, you're saying right, this, that, that y'know describing it and it makes you more aware of your knowledge like does it?"

Having the ability to apply a CBT approach seemed to allow the nurses to say (to others as well as themselves) 'this is what I'm doing, this is why I'm doing it, this is how it helps and this is what it's called'. Being able therefore, to

answer the question "what do you do?" was clearly a positive and empowering consequence of the training, not to say "I do CBT" but rather to be able to describe for example targeting distorted thinking or unhelpful maintaining behaviours:

"It's been beneficial in respect that I can say this is CBT and I can put this into practice that's been good. People ask what skills are we using, people say psychosocial interventions, but what is that?"

This again seemed to create a greater sense of purpose and empowerment within the competing mental health professions and specialities where the nurses in particular felt they had traditionally adopted a passive or at best custodial role:

"I don't feel I was backward at coming forwards beforehand but it's given me I feel more confidence to do it, 'cos we're taught you do what you're told with the doctor"

There was a strong sense from some that the active, therapeutic aspects of nurses' roles in mental health were being taken over by other professions:

"the nurses' role is kinda being taken over, we're just babysitters"

A particularly interesting dimension to the sense of empowerment was the impact on some of the research participant's affect/mood. Several described how having an understanding of the CBT approach, which in turn allowed them to be more therapeutically active as described above, made them feel better about themselves as healthcare professionals, gave them more job satisfaction and increased confidence:

"I certainly feel more confident than I did, certainly in my capacity as a community nurse, more confidence than 6 months ago, and I think some of it is obviously down to the workshops and it does give you that little bit more edge"

"In a word it makes me have a lot more self worth, I am achieving something, doing something, rather than being a little sheep I am bringing forward this patient's care"

5.6.2.3: 'Fit'

The term 'fit' in this final category is used to describe how relevant the research participants found the prospect of CBT practice, relevance to both their perceived role and also relevance to the patient or client group they were working with. Both dimensions of 'fit' are explored in this category. The meaning units for both role fit and patient fit split into either the positive dimension where CBT seems to fit well with either the patients' needs or the research participants' role identity as well as the negative dimension where there was either role dissonance or they felt that CBT was in some way unsuitable for their patients. Positive fit is evidenced throughout this category in the examples given which describe how the research participants have actually begun to work differently with patients using aspects of the CBT model.

3a: Positive fit with role identity/patient needs:

A common theme was that the CBT approach was simply a more formal framework to describe a lot of the interventions the research participants already routinely carried out and so fitted well with their work:

"Yes, but on the same hand I think I'm probably doing it anyway, I think probably I am implementing some of the techniques, but kinda unwittingly"

There was also an almost universally positive reaction to the *idea* of CBT and the prospect of the training, which suggests a strong sense of fit at least on a theoretical level:

"So when you offered the six afternoons I thought "wonderful, this is great"". "And I was like 'wow! I'd love to do that"

Many felt that the CBT training enhanced their ability to help their patients by giving them a framework to explore patients problems a) more deeply:

"even though CBT to me was about the here and now and moving forward, obviously you've got to go back and see where all their beliefs have come from and their assumptions which I find useful"

and b) more actively:

"I suppose because you feel you are actually helping them you are not being this passive listener, just kinda soaking in what they are saying you are actually

finding a way, right this is what they have told me what are we going to do about it"

"I think maybe challenging more, questioning more why they have specific feelings? Probably questioning more what the outcomes would be if they were to carry out the actions or change? I find myself questioning them more"

Fit as evidenced by research participants adopting CBT type approaches to their work was a common theme in the research data:

"Whereas now I'm asking patients to do more in-between visits, leaving homework, asking them to write things down, their own personal account"

One participant actually reflected on what the consequences for her ability to perform her job would have been if she had *not* attended the workshops:

"I said before that when we got these positions we were told we would be trained and so looking back if we hadn't had these workshops from yourself I am not sure what we would be doing with patients because it gives you that something else that you can rely on"

As well as the positive reaction to the idea of being more *actively* therapeutic with their patients, many of the research participants described being able to relate particularly well to the concept of the collaborative therapeutic relationship with the patient which is at the core of the CBT ethos. Although this was particularly true of the occupational therapists in the separate study, nevertheless many of the nursing participants clearly felt the same way:

"*And it's the whole ethos of patient participation, I like that, because that's what we should be doing (Yeah) and it's this getting them to do thing*"

Many described relating to the CBT model on an almost instinctive level:

"I also find that CBT makes sense to me, it always has you know, it makes sense and I work in that sort of, I don't know if I use all my skills or all my knowledge but I work in that sort of way?"

For those research participants working in community settings there appeared to be more sense of relevance between the CBT approach and patient needs compared to those still working on the wards:

"but now because I'm seeing them in their homes and I feel I have almost been given a blessing now I can go away and try to delve in and see what these patients want".

"In terms of delivering to people with mild to moderate mental health problems that fits, also having clear purpose and aims, repertoire you can use, that fits"

3b: Negative fit/Role dissonance:

There is evidence that for some research participants the prospect of incorporating a CBT approach into their clinical work creates a role dissonance. Deep-rooted socialisation into a core sense of professional identity is evident:

"I'm pretty black and white and a bit medical you know, like medication, the medical role"

"Yeah! so because that was the basis of our learning it was difficult to change to or do something different"

Some are aware of a process of transition involving at least partially redefining their identity:

"And it's a difficult transition 'cos y'know I worked in the wards for so long"

Perhaps the most striking example of role dissonance stemmed from the reaction to one of the workshops on panic disorder. The CBT treatment for panic disorder involves encouraging the patient to expose themselves to anxiety provoking situations and tolerate their anxieties in order that they might prove to themselves that those physiological symptoms of anxiety will not harm them in some way. This clashed at a fundamental level with how some saw their core role as nurses:

"'cos I find some of the basic principles of it were almost like the opposite of how I would"

There seemed to be a deep-rooted principle which the nurses found impossible to change whereby they believed that they must always act to relieve the patients suffering:

"when you did your training it was always like you wouldn't do, you wouldn't flood people and well if they had depression for instance you wouldn't sort of flood them into a situation they were really frightened of and it would be like a gradual process and it's having to try to change your ideas, that's what I find difficult, I'm afraid I've gone along with what I've always done"

For some the thought of seeing their patient in (albeit temporary) distress was too much:

"I would find it difficult if I was stuck in the middle of the high street with them I would panic for them because I would think 'oh! this is horrible' you know, you're exposing them to other people looking at them and you know that would be difficult for me"

Others went further and were of the opinion that their job was not to "do" CBT and that the CBT and the nursing roles were quite separate:

"But why, if you've had to go for specialised training why should I (S: aha!) be expected to do that when I haven't had the training?"

There was a sense that incorporating a CBT component into their generic role was a boundary which it was inappropriate for them to cross:

"But yet, I think it all comes back to the fact that we're all very aware, well I am, of our own boundaries, what our own capabilities are"

Some felt that practicing CBT was an 'all or nothing' situation and that you either did CBT or you practised as a generic mental health nurse:

"I think there is (H: Yeah! There is) but there's a huge grey area in between and I just feel for me it would be all or nothing"

There was also an emotional dimension present whereby some of the nurses who felt that the CBT role was incompatible with their practice and viewed CBT in rather a black and white way appeared to be angry at management for putting then in a situation where they might expected to carry out CBT type interventions with their patients when they felt that this was not their role:

"I think it's kinda daunting and I sometimes I get kinda angry that we're maybe expected to do that (H: yeah I do to) and I'm not angry with my team members, I'm actually angry with the Trust 'cos it's like a cheapening of the service sometimes"

This was interesting given that those research participants had actually volunteered to attend the workshops with no pressure or coercion from management.

The lack of fit was not solely confined to how the research participants viewed their role. There were also various instances where they believed that their patients or clients were not suited to the CBT approach:

Some viewed (especially older patients) as being too fixed in their thinking to be able to contemplate change:

"whereas the other ones are more fixed. And I'm not saying it wouldn't work, I'm just saying it would take a wee bit more planning. They have a lot more fixed ideas, they have what they envisage should happen 'I should have medicine and I should get better' and that's it"

Others felt that their patients would be unable to meet the demands of active participation in the CBT approach:

"I think they agree with the concept of it, but it's the getting down and doing it, out of all that have maybe done a diary there hasn't been many, since I've done the training I can't remember anybody who's actually written anything down and I find that a bit frustrating"

And finally some felt that their patients would be unable to adhere to the structured approach which CBT works to:

"with a lot of our patients they'll come in and you'll do all the talking then another week they'll come in and they'll do all the talking, and it's something different, they're bringing in something new or it's something else happened, you know so how do you keep a kind of structure to the sessions when more often or not it's them that's leading it?"

Recognition that some patients would not or could not engage with the CBT type approach was also however seen as a positive, allowing research participants to better assess when they might legitimately be able to discharge patients and so make more efficient use of their time:

"I do find myself though Steve, if they're not engaging I'm quicker to discharge them, I'm not hanging on, I am quicker to discharge them so maybe that is a change in me"

5.7: Category 5: Understanding and cognitive change

"It made me much more aware of what I didn't know!"

Subcategories:

1: Recognising cues.

2: Actively seeking out the model.

3: Feeling better able to understand the patient's problems and thinking about them differently.

4: Using the understanding to open up therapy.

5: Strategies used to improve understanding.

5.7.1: Introduction to the category

This category describes the research participant's ability to both understand the CBT model itself and to better understand or conceptualise their patient's problems according to that CBT framework. There is a progression of increasing understanding from passive recognition of features from the CBT model in their patients' descriptions of their problems, through actively seeking those cues to feeding that understanding back to the patient and finally using this to open up and progress treatment. Those research participants who get to that final condition find themselves in another positive feedback loop where understanding is mutually reinforced between themselves and their patient.

5.7.2: Subcategories

5.7.2.1: Recognising cues

Prior to the teaching there was some evidence that research participants sometimes struggled to make sense of patients' accounts of their problems without the benefit of an organising framework such as CBT, often feeling somewhat overwhelmed:

"and when she says it it's kinda like when you say it, it makes sense whereas before it's a bit mumbo jumbo to me, but now it's not so mumbo jumbo"

"Yeah Yeah I feel more confident the patient's problem is, as opposed to previously, you know on the first day you get this barrage of problems and you think 'oh no!"

Having understanding of the CBT model seems to give them that framework:

"*I would never have done that in a month of Sundays unless I had the framework in which I could understand the importance of such a strategy, the beauty of CBT is it's a very clear structured approach for people to get a handle on what's going on*"

At the end of the teaching all the research participants, at the very least, were able to recognise the CBT model if it was described to them and differentiate it for example from a psychodynamic formulation.

The majority were able to go one stage further and recognise key components of the model such as examples of distorted thinking or unhelpful avoidance from the patients' accounts of their problems.

"I understand most of it, like if you were to sit and explain somebody's problems like if you were to say and this is how that fits into that and that affects their mood/behaviour and such I'd say right enough"

"For me I definitely could see where it (what the patient tells of his/her problems) would fit into the model"

Some framed this ability to recognise as an increased awareness of their patients' problems:

"what I originally said, I think it makes me more aware, it makes me more aware of what the client is telling me"

This newfound ability to conceptualise a patient's problems in a coherent and easily understood framework often appeared to be associated with a very positive emotional response and sense of satisfaction:

"But I find now when I'm sitting talking to them and it just, and I think "oh yeah" and before because I didnae know, I mean I knew roughly about CBT but no a great deal and I think "ooh" "I can see where that goes or that goes" so y'know I'm starting to file in my own head"

This subcategory however only refers to an essentially passive condition. The awareness or ability to recognise does not yet translate into the ability or the confidence to use that understanding in therapy.

Some research participants recognised elements of the CBT model from their patients' accounts but were still unsure of how to progress:

"yes I understood all the things about formulations and doing all that sorta thing, but actually putting it into practice.."

"I think its more me and my confidence and I don't really know what to do with what she's telling me, I can see where it fits into the model but I don't know what to do now"

5.7.2.2: Actively seeking out the model

The next stage in the understanding hierarchy appeared to be seeking out aspects of a patient's problems which would fit into a CBT approach. This is a more active condition than the passive recognition described in the previous subcategory in that the research participants know what they are looking for, why they are looking for it and where, potentially in might fit into their overall understanding:

"So I'm going out there and yes I have a better understanding and yes I'm looking for different things to before we did this"

"I'm looking at specific things I'm looking at automatic negative thoughts, analysing them more, you know the things my clients are saying"

Some, as well as looking for key triggers or cues which would suggest fit with the CBT model, also described being able to use the overall CBT framework to guide their clinical work:

"I felt it before but I felt it was more luck than judgement, more hit and miss previously, I feel more confident targeting the problem now so I suppose yes formulating what I'm actually doing"

5.7.2.3: Feeling better able to understand the patients' problems and thinking about them differently

The consequence of either recognising or actively seeking out correlation between the patients' problems and the CBT model was that many of the research participants felt they now had far greater insight and understanding of the patients' problems. This is not to say that they merely were able to display more empathy for example, rather their understanding was functional and conceptually organised, not simply understanding *what* the patients' problems were but *why* there were experiencing them and *how* they were maintained:

"Well really where you were saying as well to go back to where it started, and then her behaviour how it's changed after and how it's changed her lifestyle, so they can identify 'this is what's happened to me, this is how my behaviour's changed or how my thoughts and behaviour has changed"

"It's obviously working against them, isn't it? They're assuming through their, whatever they've picked up from other people's behaviours or thoughts, maybe their parents? Has very much a bearing on how they're going to work through their particular sessions. So you have to like question: "well where did that come from?"

"I feel they give me a better understanding of why people are suffering from these illnesses from the way they are thinking the thought process and the way their perceptions are"

There was also strong evidence of a corresponding change in how they typically **thought** about their patients' problems:

"Yeah but even looking at it, you're maybe looking at their problems from a different angle from what I would have before"

"I think about things a lot more now. So I think I've gained out of that". "So I'm going out there and yes I have a better understanding, and yes I'm looking for different things"

5.7.2.4: Using the understanding to open up therapy

The increased understanding of the *how* and *why* of a patient's problems then typically allowed the research participants to begin to feed this back to the patient and so crucially begin to actively and collaboratively engage the patient in treatment:

The first evidence of this in session was often their tendency to structure and plan the sessions to gather the information the felt they needed:

"before I basically sat down and listened to their life story writing stuff down I thought was relevant, but I now 'can I stop you there' 'Discuss around that bit' 'that was your view' more direction"

Then they could use reflective skills to facilitate increased self-awareness and understanding in the patient:

"it's quite funny one patient said to me the other day for the last 20 mins she is much calmer, she always says "why is it whenever you come to speak to me you can calm me down" at first I don't know then I think perhaps it is because I can rationalise how she is feeling and then reflect that back to her and because somebody is saying you are probably feeling this way because of xyz it gives her this better understanding"

What then seems to occur is the second positive feedback loop described in the results section of this thesis (see '*on the threshold*' core category) where the patient is able to add to, correct and elaborate on the research participant's verbal formulation and so on:

"I feel they give me a better understanding of why people are suffering from these illnesses from the way they are thinking the thought process and the way their perceptions are and in turn that allows me to feed back to these patients what I think is causing the problems"

"It's the breakdown of barriers as well cos you're actually explaining what you do (yeah) and you're giving the person an opportunity to challenge this model"

"and it was almost like you could just suddenly, once it had been explained to them and you were thinking, this is because of this and this is blah blah blah, it was like somebody had developed the right pieces of a jigsaw you suddenly slot

into place and they were able to sit there and go " yeah that's right I am feeling like that"

"They start opening up and telling you things and you're like throwing things back at them"

5.7.2.5: Strategies used to improve understanding

The research participants' understanding of the CBT model and its relevance to patients' problems was always at best partial at this early stage of their development:

"I've got some of the theory behind it y'know (Yeah) but I have'nae completely grasped a lot of it"

Some did describe confusion and uncertainty with a consequent lack of confidence in pressing ahead with the approach. They described particular difficulty holding onto an internal representation of the model, which would allow them to establish a fit between the model and a patient's story there and then in session:

"That it that's got a lot to do with it and I don't have the model fixed in my head, I really have to think about it and I get confused"

Some therefore used a written representation of the model as a framework to help understanding:

"I've got an A4 photocopy of the model, and I take it right? And I start and when I speak to patient I say we will put that in there and that in there and it makes me feel better 'cos it's like trigger points to me to explain it"

Whilst others returned to source (i.e. a text book or handout) each time to help understanding and refresh their memories. Some found that the process of drawing a diagrammatic model of a patient's problems was a useful aid to developing understanding:

"I've actually been writing out more of a hypothesis its more of a (?formulation) yes, my perception of the patients problems and where they come from and as well as allowing the GP to be aware its allowing me to be able to crystallise it on a bit of paper and say "yeah! That's right"

A further strategy used was to forego any attempt to draw conclusions or offer verbal formulations *during* the sessions and instead allow themselves time and space in private reflection to think about things with the pressure off:

"'cos I don't think that I'm confident enough to sit there and say "right this is how you are, this is how I see it, this is what you're saying (Yeah) I prefer to go away and think about it first and then come back to the patient"

5.8: Discussion and conceptualisation of the results

5.8.1: Discussion

The research participants in this study clearly found applying their CBT training a complex and at times difficult process. All the participants in the study who attended the informal six workshop series had the choice of whether to attempt a CBT approach with their patients or not. In the categories to emerge from the grounded theory analysis, this choice is represented as a threshold which they must decide to either breech or step back from and decide not attempt to apply the training.

The emergence of this threshold as a concept and the experiences of the participants during the process of crossing it, is at the core of this study. Those interviewed from the Diploma CBT course for triangulation purposes also made reference to such a threshold, but here it manifested itself slightly differently. These students were to an extent *forced* over the initial threshold by the demands of the course, dictating that they **were expected** to carry out CBT, but nevertheless experienced similar mini-thresholds later in the process as they attempted to progress with their CBT practice and move for example from assessment to treatment.

Awareness of one's own limitations when faced with the prospect of applying newly learned skills, particularly in a situation where a patient's well being is at stake, must be considered normal, appropriate and entirely functional. The vast majority of the participants in this study however, described a selection of the familiar list of cognitive distortions which might typically emerge when working according to a CBT model with patients suffering from either anxiety or depression, albeit here at a sub-clinical level. The main evidence to support this key contention, central to the findings of this study, that these 'negative thoughts' are in fact distortions, comes from the participants themselves. Many times during the interviews, they showed unprompted insight into the inaccuracy and unhelpfulness of these thoughts and appeared to be engaged in a mental battle with themselves to obtain a more reasonable perspective on their situation. Many of these self-challenges are documented in the 'overcoming difficulties' category of this chapter.

The concept of dissonance emerged as a central theme from the analysis in several contexts. The cognitive distortions referred to earlier seemed essentially to result from an exaggerated sense of what might be required from the therapist to provide an 'authentic' CBT approach and a correspondent under-valuing by the participants of their own skills and abilities. The dissonance can therefore be seen as a consequence of the perceived gulf between what they felt they were and how they felt they **should** be.

In the category 'Negative Thinking' several examples of this emerged. The research participants described an idealised fantasy of how specialist CBT practitioners might work with patients. They expected variously that they should have been able to "cure" patients, castigated themselves as failures when the therapy hit a difficult patch and viewed CBT itself as only being valid when applied as a total, by the book approach with all the boxes ticked. The predominant affect consequent to this was anxiety, anxiety caused by a fear of failure, of being found lacking by other professionals or, just as commonly, by the patients themselves. Other emotions which emerged, as much from the tone of what was heard on the audio-tapes as the actual words transcribed on the page, included doubt, embarrassment, dread and at times outright fear.

Distinct behavioural consequences of these thinking styles and negative emotions also emerged from the data analysis. The most common of these was avoidance or a reticence to progress with therapy which ranged from unwillingness to actually begin a CBT approach to remaining in the subjectively *safer* assessment phase of treatment for an unduly lengthy period of time. The avoidance, which included procrastination and delay, was of course functional insofar as it protected the participant from what he or she feared, i.e. failure. Unfortunately it also precluded her from the process of consolidation and reinforcement described in the 'on the threshold' category as a positive feedback loop between therapist and patient, thus prolonging the period of anxiety and uncertainty. Another example of unhelpful behaviour to emerge from the data was overcompensating. This included "waffling" and trying to cram too much into a session. Again this behaviour served a function in that it was an attempt to compensate for the research participants own perceived shortcomings. As with the avoidance however, it only ultimately served to create more problems such as creating confusion for the patient.

It is worth pointing out at this stage that this researcher is in effect using a cognitive-behavioural representation to conceptualise this analysis of the results. What has emerged is the familiar (to cognitive-behavioural therapists at least!) cycle of cause and effect between thoughts, emotions and behaviours with the behaviours ultimately serving to reinforce the negative or distorted thinking of the learners.

A diagrammatic representation of this conceptualisation is included at the end of this section.

The data also offers numerous examples of where research participants manage to successfully to resolve this aforementioned vicious cycle by '*breaking it*' through re-framing of how they perceive their situation and/or how they actually behaved. These are described in the 'Overcoming difficulties' category. What the participants did essentially was to breach these thresholds by in effect lowering them. They did this in three basic ways: Firstly they lowered their expectations of themselves and came to more reasonable expectations of the part that they should be playing in therapy. Secondly they shrunk what could be described as the 'gravitas' of CBT, in effect taking it off its pedestal and making it more of a pragmatic tool to be used rather than an abstract and academic approach to feel in awe of. The final strategy employed was to effectively *circumvent* the mountain which is CBT, by neither referring to it openly by its name to patients nor admitting to being able to provide CBT either to themselves or colleagues. They instead adopted *elements* of the approach, usually those which they felt most comfortable with such as the link between thoughts and emotions or more generally the collaborative, shared responsibility approach without actually naming what they did as CBT, therefore easing the self-imposed pressure on themselves. This last option again was only really open to those participants in the main study and not to those interviewed from the Dip CBT course. Interestingly whilst both groups described similar anxious and negative thoughts in relation to application of the CBT approach, it was only those learners on the Diploma course who described feelings of being overwhelmed:

"Phenomenal pressure, and now I'm at the stage well is the course actually double for me over 9 months, the preparation, the thinking about formulations,

the thinking about the kind of person you are gonna see, the background reading that's required, and trying not to just pigeon-hole the person or see them as a label but to try and think about the way you are going to..."

It seems likely that the choice of how, and indeed if, to apply the approach, the option of selecting relevant or more easily understood parts of it and above all the luxury of working at their own pace, allowed the informal workshop participants from the main study to avoid or at least lessen this feeling of being overwhelmed.

The analysis of the data suggested that the participants' sense of professional identity, and how it interacted with the training was the arena where the struggle with negative thoughts was fought and potentially overcome. The prospect of applying a CBT approach necessitated them broadening their existing sense of professional identity to encompass this new extended role. Where there was a gulf at the threshold of contemplating the new approach between how they viewed themselves and a generalised fantasy about the kinds of people who might legitimately use CBT (the "specialists" and "professionals" referred to in the data), then the dissonance occurred, leading to negative emotions. This dissonance was at its most apparent with the two heterogeneous cohorts from the main study who attended the informal workshops. Despite relating well to the teaching, showing clear understanding of its central tenets and being able to identify how and why it was relevant to their patients needs, they all shied away from overtly stating that they could 'do' CBT. They were reluctant to describe the approach they were proposing to patients as CBT and held back in team meetings when a CBT approach was asked for despite feeling able to work this way with patients. They also made reference to for example "*you guys*" meaning CBT specialists, drawing a conscious distinction between themselves and other more specialist workers, again fantasising that they, myself included, would always know what to do and never get 'stuck' with patients. Those research participants who were interviewed from the Diploma CBT course expressed similar concerns, although less frequently, for example questioning what gave them the right to be sitting with a patient offering therapy, implicit in

this being the opinion that there are other groups who possessed greater legitimacy then they did

What the participants did when they shrank the dissonance, allowing progress with therapy and their development as therapists, as described in 'overcoming difficulties' was to assimilate aspects of this new role into their core professional identity. They did this by making it more informal, dejargonizing the terminology, stripping it of any perceived academic pretensions and making it a more useable, pragmatic tool, commensurate with their own sense of identity.

The research participants' understanding of the theory and application of CBT at the end of their training was obviously partial and incomplete given the brevity of the training and lack of significant opportunity to consolidate the training. Most however described at least being able to passively recognise key triggers such as negative thinking or unhelpful behaviours from patients' accounts. This awareness or ability to partly conceptualise the patients' problems proved to be something of a double edged sword. It brought them closer to the stage where they might decide whether to actively pursue the CBT approach or not. Some described going to the next stage and actively questioning, looking for the evidence to confirm or disconfirm a likely CBT formulation. The next step in understanding however appeared to be potentially the most difficult and neatly fitted in with the aforementioned concept of a *threshold* to be crossed. This was the participant offering his or her understanding as a tentative formulation to the patient for their comment. This at times acted as a catalyst for all the negative thinking around issues of identity mentioned already in this study to crystallise. To offer a formulation was viewed in effect by the research participant as offering his or her opinion. For some nurses especially, this was outwith their typical clinical experience or role, their clinical opinions having apparently rarely been sought or offered. Some of the participants in the study equated this with a doctor making a diagnosis. Several described strong beliefs that any such formulation had to be 'right', fearing the consequences of it being wrong or incomplete. Again, this is another prime example of the recurring theme of dissonance, this time role dissonance, to emerge from this study.

Many research participants found that giving themselves time to consider their hunches, perhaps checking through books or handouts from the workshops or discussing the case with colleagues gave them sufficient courage to 'take the plunge' and offer their understanding/formulation to the patient. Significantly, none of the participants described any negative reactions from the patients when they did this. There was of course occasional disagreement but some saw this as positive in that it at least gave them a basis for discussion and drew the patient into a more active role i.e. 'if this is not totally correct help me understand how to improve it'. The 'on the threshold' core category makes reference to a 'positive feedback loop' where the patient and therapist took it in turns to clarify, add to or simply offer other relevant examples of whatever understanding they had reached, thus developing and improving the a shared sense of understanding. The participants, once they 'took the plunge' and attempted to frame the patients' problems in a tentative cognitive-behavioural framework, seemed to learn here was that it was permissible, indeed normal to 'not quite get it' without first directly enlisting the patients help to develop understanding. Their suggestion of a possible formulation of a patient's problems allowed the patient to respond and either confirm the participant's suggestion or at least correct the participant's misconceptions. Either way it opened up communication and genuine collaboration dispelled some of the participant's fears about the patient's possible negative reaction to their first attempt to use CBT and gave the patient something concrete to work with. This then seemed to enter the cyclical process illustrated in figure 6.

Overall the 'understanding' category illustrates several of the main themes to emerge from the analysis. The concept of a threshold, the need for the threshold to be breached before the problem (in this case partial understanding) can be resolved and the dichotomy between the learners' beliefs that they should be expert and the obvious benefits of a more collaborative approach where the responsibility for constructing understanding is shared with the patient. The category also again shows how the extended CBT role, in this case trying to construct a formulation of the patients' problems created role-dissonance related to the learners' sense of professional identity.

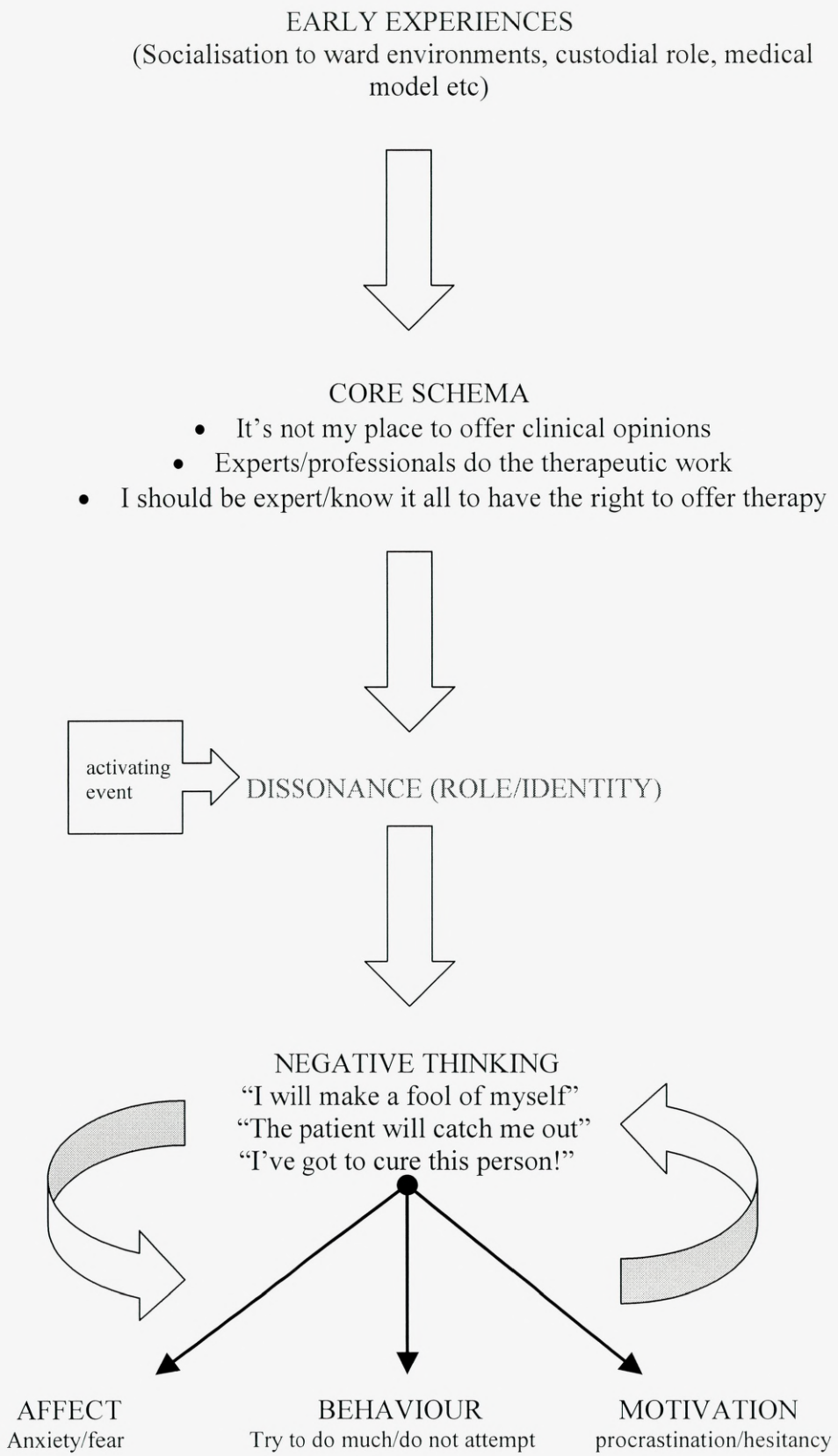
An interesting dichotomy emerged from the analysis in that despite the anxieties and difficulties generated by the task of integrating a CBT component into their core professional identities CBT was nonetheless viewed almost universally as positive, valuable and useful, something which the research participants felt they should be routinely using. Hence, in all probability, their willingness to persevere and overcome despite these difficulties. The main reason for this seemed to be that they felt CBT was empowering, particularly for the nurses interviewed, giving them something concrete, definable and helpful, which they, personally could use to the benefit of their patients, roughly equivalent to the psychiatrists main role of having medication to offer. In the 'identity and relevance issues' category many of the nurses made reference to feeling disempowered, aimless, and subordinate to medical staff. Some actually reported believing that they had been actively discouraged from taking a more active therapeutic role with patients especially in ward situations. Their reaction to the skills which they felt that the CBT training had afforded them, was described by some as "liberating" and leading to a greater sense of self worth. As a consequence, several participants described being more forthcoming with medical staff, making suggestions of their own and generally feeling on a more equal footing. Even those who did not progress with the CBT approach for various reasons still described the belief that CBT training had the *potential* to enhance their sense of role and therapeutic identity.

5.8.2: Conceptualisation of the results.

The two diagrams (figures 8a and 8b) represent the conceptualization of the research participants' experiences as summarized in this section. Firstly the way in which firstly their unhelpful negative cognitions can inhibit the process of training transfer and secondly how the innate strategies which they develop can overcome these internal barriers to transfer and actually facilitate the progression of the CBT approach.

The format of the model used here is identical to that used in the bulk of the CBT training literature (Hawton et al, 1989) to conceptualize a patient's clinical difficulties with either anxiety or depression using a cognitive-behavioural analysis.

5.8.2.1 Figure 8a: Cognitive Behavioural representation of Theory (I)

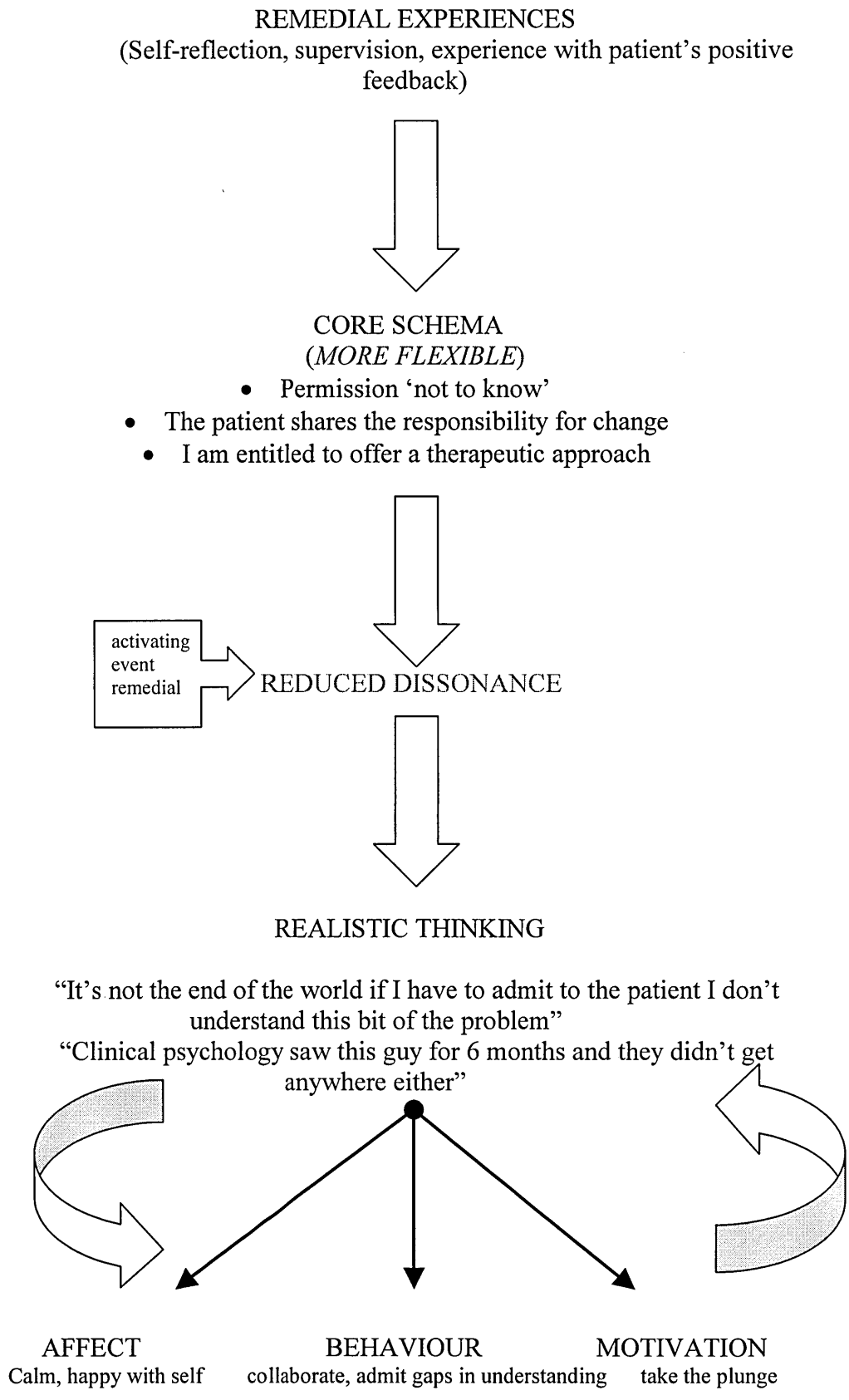


The first stage in this model '*Early Experiences*' represents the period in the research participants' professional history where they were socialized into a sense of professional identity, most commonly in this study that of 'nurse'.
The second stage in the model, 'Core Schema' is an account of the cognitive or mental structures which develop through that early experience and which the participants use to make sense of their interactions with their professional environments, in other words their rules, shorthand or expectations both of others and of themselves. Typically from this study these might be:

- It is my responsibility to make the patient better
- It is wrong to ask the patient to endure distress
- It is not my place to offer a clinical opinion
- CBT is something done by those far more qualified/experienced than I am.

The third part of the model, the '*Activating Event'* is the delivery of the CBT training to the research participants. The prospect of applying this training in their clinical work does not fit with the participants pre-existing role-concept of themselves, or their beliefs about other professional groups leading to the fourth component of the model '*role dissonance.'* This is the discrepancy between how they see themselves, their legitimate historical role, their abilities and what they perceive the demands of carrying out CBT to be.
The fifth part of the model, '*negative thinking'*, occurs directly because of this dissonance, in effect its cognitive manifestation and leads to uncomfortable or distressing affective consequences such as anxiety, fear or low mood due to the predictions of for example failure. The behavioural and motivational components of the model represent the research participants instinctive drive to reduce the dissonance and hence the feelings of anxiety etc. These manifest as behavioural strategies, typically or deficits of behaviour i.e. trying too hard or avoidance. As was described earlier in this section however these tend to be counter-productive and either lead to the participant opting out of the attempt to apply the training or at best rendering it more difficult than it need be.

5.8.2.2 Figure 8b: Cognitive Behavioural Representation of Theory (2):



This second illustration uses the same basic model to represent what happens when the research participants begin to overcome the difficulties presented in the previous illustration. It describes in effect a re-learning process whereby through an inter-linked combination of practice and questioning of their own belief systems, the participants are able to progress their application of the CBT approach.

The learning from the early experiences from the first illustration is replaced by '*remedial experiences*' such as supervision, self-reflection or crucially the proposed changes which would be made to the teaching as part of the action-research cycle for this study. These would allow the participant to challenge and modify the unhelpful core beliefs or schemata described in figure 8a. The more flexible schemata which result from this re-learning allows the participant to accommodate the challenges of providing a CBT approach within his/her sense of core professional identity because a) the concept of what CBT entails has been *shrunk to fit* either through not naming it so, only selecting parts of it or reframing it as many in the study did as "*not rocket science*". This results a more neutral affective state which then allows the participant to display more functional, adaptive behaviour such as sharing responsibility for change with the patient or taking the plunge and offering a tentative formulation. This then leads the participant into the aforementioned positive feedback loop where in effect the momentum created carries the process of therapy forward.

Chapter 6: The Occupational Therapist Study

"You can't really take someone down town without asking them what's going on upstairs"

6.1: Introduction to the chapter

In the foreword, as well as in the Design chapter of this thesis, the inclusion of this, separate but thematically and methodologically identical chapter which focuses on occupational therapists rather than nurses is explained and justified primarily in terms of enhancing the reliability and validity of the study through data-source triangulation. Further discussion of the utility of this chapter is found in Chapter 7 of this thesis.

This chapter is structured as a separate 'study within a study' in the form of a paper or journal article, which this author intends to submit in modified form, for publication.

Occupational therapists' experiences of integrating short-course cognitive behavioural therapy training into their core clinical role: The influence of professional identity on psychological barriers to training transfer.

Abstract

Nine occupational therapists were interviewed following their attendance of a series of cognitive behavioural therapy (CBT) workshops. A grounded theory analysis was used to explore and develop understanding of how their sense of professional identity both influenced and was influenced by the training. A central theme of 'role dissonance' emerged as a potential barrier to training transfer. This research describes the cognitive basis for that dissonance and locates it within the ongoing debates within the occupational therapy literature on role ambiguity and specialist vs. generic practice.

6.2: Introduction

The concept of "role dissonance" has emerged as a central theme in this author's doctoral research project, exploring the impact of short-course CBT training, primarily on mental health nurses. These nurses described varying degrees of incongruity between their existing core professional identity and the demands which they *believed* integrating a CBT approach into their clinical repertoire would make of them.

The analysis suggested that the nurses training in CBT displayed thinking errors broadly similar to (although less extreme and strongly held) the patients/clients they typically treated. Typically this would involve on the one hand undervaluing their own skills and abilities yet simultaneously overestimating what would be required to legitimately offer a CBT approach. The issue of dissonance arising from the challenge of adapting their clinical role to accommodate a CBT approach within their existing sense of professional identity was central to this negative experience. In essence, the adoption of a CBT role, for some, represented an uncomfortable divergence from their core professional identity. This created a psychological barrier or threshold, which partially inhibited the nurses, thus inhibiting training transfer.

This study (within a study) aims to understand the impact of attending the same short course CBT training on a *different* group of health care professionals namely occupational therapists. Occupational therapy as a profession is currently struggling with its own difficulties in establishing a coherent professional identity (Thorner, 1991), which in turn manifests itself in problems with role conflict and ambiguity (Bassett & Lloyd, 2001). Although all the occupational therapists in this study self-selected for the training, there have been concerns expressed that occupational therapists practising CBT may be diversifying from their core focus on activity (Rebeiro, 1998) and that it may result in role blurring with other professions (Kaur et al, 1996).

6.3: Literature Review

Many occupational therapists now routinely use CBT. (Harrison & Hill, 2003). Meeson (1998) reported that CBT was the 8th most common out of 21 interventions used by occupational therapists in community mental health settings. Significantly, anxiety management, which has at its core a cognitive behavioural rationale, came second. Craik et al (1998) reported many occupational therapists wanting further training in CBT and indeed the occupational therapists who participated in the training for this study self-selected for the study.

The need for good quality, regular Continuing Professional Development (CPD) for occupational therapists is well recognised. The College of Occupational Therapists recently published a standard proposing a minimum of one half day per month for CPD activity (Ilott & White, 2001).

The popularity of CBT with many occupational therapists may be due to certain similarities in approach. Comparing a recent definition of occupational therapy (Creek, 2003) with the definition of CBT from the British Association of Behavioural and Cognitive Therapists (http://www.babcp.org.uk/), large areas of overlap become apparent: emphasis on client/therapist collaboration, active client participation, definition of specific measurable problems and goals, the focus on observable behaviour or activity and the importance of the meaning which the client ascribes to his/her activity.

Additionally, the strong evidence base for the clinical effectiveness of CBT (Roth & Fongay, 1996) is attractive to occupational therapists (Harrison & Hill, 2003) who place high value on the use of research based practice (Humphris et al, 2000).

Exactly how an occupational therapist's role should be defined to differentiate it from other members of a multi-disciplinary team and consequently the form of therapeutic intervention which occupational therapists might legitimately employ, has been the subject of much debate (Reeves & Summerfield Mann, 2003; Taylor & Rubin, 1999).

Role blurring is recognised particularly in community mental health teams (Parker, 2001) where pressure to adopt a more generic role leads to dilution of occupational therapists' professional identity. Maintaining a coherent sense of

professional identity has been identified as a problem for occupational therapy (Creek & Feaver, 1993) and is described as a potential source of stress (Leonard & Corr, 1998).

Hughes (2001) in Parker (2001) postulated that these problems may be partly due to occupational therapy's lack of grounding in a statutory role such as social workers or doctors, as well as its lack of a literal purpose inherently understood by the implication of its name unlike for example nursing equating to 'to nurse'

There is a debate as to how occupational therapists should (or indeed *if* they should) integrate generic (i.e. non occupational therapy specific) interventions into their practice (Lloyd et al, 2004), which Meeson (1998) characterised as a conflict between two schools of thought: One which would accept occupational therapists using generic, for example psychotherapy, skills in isolation and the opposing viewpoint which held that these should only be used when "synthesised into the performance of a routine or creative task".

Even the definition of what constitutes a generic or specialist intervention is debated. Clark (1999) argued that occupational therapists should focus on purposeful activities such as relaxation training, or problem solving. Duncan (1999) however, points out that these are actually based on a cognitive behavioural foundation and could legitimately therefore be described as generic.

Opinions differ as to how these issues of role and identity should be resolved: Durose & Leeson (2002) felt that a clear statement was required, defining the function, core skills and unique approach of occupational therapy. Smith (2002) disagreed, arguing that the issue was not what the occupational therapy role should be but instead how evidence based practice could be best integrated by occupational therapists into their practice. Lloyd et al (1998) adopt a compromise position stating the need for occupational therapists to strive to keep their unique identity but simultaneously extend their role and integrate new practices from other professions into their own repertoire.

There exists therefore a potential dichotomy. CBT is already being practised routinely by occupational therapists who want more training, can appreciate its overlap with key principles of occupational therapy and believe that its evidence base enhances their own status. Alternatively, generic interventions such as CBT are seen as diluting the uniqueness of occupational therapy, adding to role

blurring, eroding the occupational therapists sense of identity and potentially creating additional stress.

6.4: Methodology

6.4.1 Design

The research design was qualitative, using a grounded theory (GT) (Glaser & Strauss, 1967) methodology to inductively develop theory from the collected data. Curran & Williams (1999) described researchers using the naturalistic (qualitative) methodologies as trying to

1.Understand the meanings of events within a natural setting
2.Understand research subjects' own understandings of their experiences and apply these to the particular context under study.

This is wholly consistent with the stated aims of this study.
Grounded theory has been described as being "ideally suited to areas of health care where there is little existing knowledge" (Barker, 1999) whilst Charmaz (1995) sees it as being useful when exploring social psychological topics such as personal experience, identity and conflict.
Although grounded theory is a well-established methodology in the field of social science, education and health care research (Annell, 1997; Bogdan & Biklen, 1997) it is less well established in the field of occupational therapy research where the most common qualitative research methodologies appear to be phenomenology (Dawkins & May, 2002) and ethnography (Wright, 1998). Stanley & Cheek (2003) however make a case for occupational therapy to make greater use of grounded theory in order that the profession begin to address the shortfall of mid-range substantive theories specific to occupational therapy

6.4.2: The Teaching

The teaching consisted of six, half-day weekly workshops. The content of these workshops was essentially an introduction to CBT, its theoretical basis and its application to the more common mental disorders.
The teaching combined didactic instruction along with opportunities for more informal discussion, case review, and role-play. There was no formal assessment or examination. The author of this study was the sole teacher throughout the teaching.

6.4.3: The research participants

The participants consisted of eight occupational therapists who all attended the above series of workshops plus one other who had attended a previous series. All self-nominated. Three of the nine therapists worked in mental health, six worked in a variety of medical settings including community rehabilitation and general medical.

6.4.4: Ethical Considerations

Ethical approval was sought from the local Health Authority ethics committee but was deemed by then unnecessary as no patients were involved directly in the study. All participants gave verbal permission for inclusion in the study and the interview transcripts were edited to remove any personal details and preserve their anonymity

6.4.5: Interview Procedure

All interviews conducted for this study were formal in that they were pre-arranged with the informants for the specific purpose of data collection. The interviews were semi-structured (Polit & Hungler, 1987). Areas of interest generated by emergent theory from earlier interviews were followed up, but were always flexible enough to allow new leads to be followed as intuition suggested during the interviews.

6.4.6: Data Collection

The interviews were audio taped individually or in pairs with participants. Once collected onto audiotape, the data was then manually transcribed verbatim onto paper.

Data collection and analysis was carried out exclusively by the author, partly because of pragmatic considerations but also in order to maximise the potential for understanding which occurs when the grounded theorist engages in data collection as well as analysis, affording a greater sensitivity to the more subtle nuances of meaning and process under analysis. (Charmaz, 1995)

Given that this cohort was the third to be studied for the purposes of this research and therefore certain themes and robust categories had already emerged from previous cohorts, sampling was purposeful i.e. increasingly reflecting the needs of the study (Glaser, 1978) although in reality all but one of the therapists were interviewed with another being interviewed on two occasions.

6.5: Data analysis

Analysis began by open or Level 1 coding naming and ascribing meaning to each line wherever possible in active and specific terms to create *substantive* codes. (Glaser, 1978). The constant comparative method was used to generate theoretical constructs from the substantive codes. Incident was compared with incident, incident with category and finally category with category (Hutchinson & Wilson, 2001). This process allowed the structure, dimensions and properties of the second level of codes or *categories* to emerge, also leaving an audit trail (Rodgers & Cowles, 1993) Memos were kept throughout, asking questions of the data, recording hunches, assisting with the comparisons and ultimately helping to develop the increasingly conceptual categorisation of the data (Charmaz, 1995).

The third stage of coding involved theoretical sampling (Strauss & Corbin, 1990). Here analysis was more selective as data was sought specifically to develop, test and refine emergent theory.

Finally after basic social processes had emerged, sorting of categories was worked through in an attempt to create a coherent whole or parsimonious set of integrated concepts (Glaser, 1978).

The analysis phase was considered complete once it was felt that *saturation* had been reached i.e. that additional data led to no further development of categories/concepts.

6.6: Results

6.6.1: Summary of categories

Core category: 'attempting to accommodate the (CBT) training within the specialist occupational therapy role identity'

Three main categories emerged from the analysis:

CATEGORY 1:

Reflections on professional identity

Subcategories:

1: Reflecting on limitations of existing practice

2: Reflecting critically on the norms of existing practice

3: Being able to relate to the CBT model

4:The influence of prevailing organisational culture/management on therapists attempts to apply training

CATEGORY 2:

Encountering psychological barriers to the application of the training
Subcategories:
1:Opening a can of worms
2:Confidence issues
3:Legitimacy
4:Unhelpful rules
5:Anticipating negative reaction from clients/relatives/other staff

CATEGORY 3:

Using strategies to overcome difficulties in applying the training
Subcategories:
1:Pragmatic strategies
2:Psychological adjustments
3:Creating a sound therapeutic relationship

6.6.2: Category 1: Reflections on professional identity

Subcategory 1: Reflecting on limitations of existing practice

Prior to commencing the training, many of the (physical) occupational therapists described their main motivation for coming to the workshops as being awareness that in their routine practice some of their patients needs were at times not being met. Essentially this was recognition that there were often underlying psychological issues which were adversely impacting on their clients recovery and were perhaps a more appropriate focus for intervention than purely functional approaches. They felt that they either did not have enough time to explore these issues or did not feel confident enough too

"Yeah, they are the ones who get stuck, they are the ones who no matter what you put at them treatment-wise, you're not getting very far with them because it's not actually what they presented as the problem was the problem"

"You're already you're in there, you've been referred for physical reasons but what we find is we have unsolvable problems and they're not quite tangible"

Existing practice was viewed as somewhat one-dimensional with a focus on functional issues, activity and problem solving *for* the client:

"it's much more physical, y'know it's I can't get on or off the toilet or I can't make the dinner, can you solve it?"

"I feel that OT's quite concrete, in it's quite clear in what the functional problems are, and what the solution"

Subcategory 2: Reflecting critically on the norms of existing practice

Undertaking the training seems to have caused many to reflect still further on their routine or core practice as occupational therapists. Some described a process of socialisation into a kind of occupational therapy shorthand due to pressure of time or size of caseload where 'doing for the patient' or 'fixing' the problems became the norm.

"and I think especially when we first came into this kind of atmosphere/department it probably felt quite uncomfortable that we weren't going there, but, so the problem is you do become desensitised to it all"

"And I think that's very much how we perhaps got into that routine of trying to change people's behaviour without perhaps tackling some of the cognitions which are going on behind it"

Underlying psychological issues, which may have been preventing the patient from progressing, were overlooked or avoided. The therapists describe pressure to achieve turnover of the patients in the quickest possible time with this leading to a gradual erosion of the ideals which they brought with them into the service

and consequent dissatisfaction. Again this was described mainly by the physical occupational therapists.

"'cos I just maybe wouldn't have the time to do it with her so I think we do do a lot of these sort of joining up things and sort of spelling it out to people which isn't allowing people the confidence to do it for themselves"

"and I think as OT's we like to think we are looking at somebody holistically, but as T was saying we do get swept along in the culture"

Both the physical and the mental health therapists interviewed showed awareness of the necessity to take psychological issues into account when delivering care, reflecting on the folly of focusing purely on function or activity:

"it's because we are not investigating the psychological part of what's going on, we're just really thinking 'we've solved all the physical problems, what now, why can't you do it ? and how wrong are we to expect that?"

"but I think that certainly CBT is part and parcel of it and you can't really separate the parts, you can't really take someone down town without asking them what's going on upstairs"

Some described significant discrepancies between the ideals they were taught during their occupational therapy training and the reality of life in the NHS:

"In 'real OT world' you would be and should be but what's happened to our role is it's been kinda eroded away because of the culture and the change in the health service so what we should be doing its kinda being phased out of..."

Others describe being socialised at an early point in their careers into a more pragmatic "do for" approach:

"if you had to put a label on how I was being trained it was bio-medical okay? You sort the patients out, you deal with the problems that are there medically, you deal with them and fire them out the door"

Both groups however had developed awareness of deficiencies in their practice and were keen to remedy the situation:

"so I feel for me it's new for me but it's also kinda going 'wait a minute is this not what I should have been doing in the first place?"

One occupational therapist described an internal conflict going on where she struggled to resist the habit of resorting to the default '*doing for'* mode:

"Part of the thing is I think it's about re-training me as well stop myself being "job done then.." "

The brief CBT training was clearly not 'the answer' to these complex issues but it did at least initiate reflection.

Subcategory 3: Being able to relate to the CBT model

CBT was seen as a practical, easy to understand approach, which allowed the therapists to better understand and conceptualise a client's problems, offering a potential solution to the aforementioned recognition of unmet need in a proportion of the clients:

"Yeah, like the whole concept is very straightforward, it's very logical it's very methodical the way you can sort of go about it so you know it's quite easy to understand"

"I just like the idea, I think also the concept of what as OT's we would go in and see the problem and we would start offering aids and if mentally you are not wanting to do that anyway, no way it's going to work and I think that's why the CBT thing is interesting to tackle it from the other side"

It was seen as a basis for allowing the therapist to go deeper and begin to explore some of these underlying psychological issues:

"I suppose it's given me a bit more confidence of being able to broach and open up and be prepared to say to our patients 'do you think there is some other reason for this happening?' 'for you acting this way for you feeling this way' and be a little more confident in asking that questions we always say we don't have answers for everything before we start but you are able to feel a bit more confident on being able to tackle that sort of..."

There was considerable variation in which aspects of the model the occupational therapists were most able to relate to. Virtually all related positively to the concept of shared responsibility and collaboration which is at the core of the CBT approach:

"You're going to have to want to do it, and if you don't want to do it then it's okay for me to say, "Sorry I can't help you"
Me: Did that kind of philosophy appeal then?
Yes! (Laughs!) But I think that's a much more realistic (T: yes!) way of looking at things,"

The medical occupational therapists in particular were unhappy at how their role had developed into one of taking all the responsibility to 'fix' a clients problems for them and generate solutions without considering relevant psychological aspects and saw a CBT approach as potentially facilitating a worthwhile broadening of the approach:

"but we weren't sitting down with them and saying 'before you even start the activity mentally what are you thinking about the activity? Are you going in there already feeling defeated?' as I say it was practical solutions"

Most felt that what could be described as the 'bottom end' of the CBT model i.e. the chain of consequence between thoughts feelings and behaviour along with the more behavioural aspects of CBT such as keeping a diary and exposure work, was of particular relevance to their practice:

"I feel fairly confident, yeah, obviously there's parts of it I'm not too confident with but the basic nuts and bolts, yeah! I'm quite happy, as I say it's part and parcel of me, the OT and the way I'm working at the moment"

"and it was more the sort of ABC model which is a lot more 'this leads to that' rather than the retrospective work, schemata and such. Yeah it was a good part of my work I feel"

The more conceptual aspects of the 'top end' of the CBT model such as dysfunctional schemata, critical incidents and key developmental life events were viewed as having less relevance to the therapists identity as occupational therapists, as they had less to do with observable function, tangible goals and 'here and now' focus:

"I would say that looking at the formulation aspect and getting an understanding of people I've not been looking at that at all because I feel that that's quite separate to what my focus should be as an OT"

Subcategory 4: The influence of prevailing organisational culture/management on therapists attempts to apply training

Attitude to overtly psychological work:

Some believed that their managers would frown upon them changing the focus of their work in any significant way from functional/physical approaches to overtly taking psychological issues as a main focus. It was however deemed acceptable to *tag* some psychological work onto a primarily functional approach:

"I think that would be more what was expected from our management. They wouldn't be adverse to me looking at that but they wouldn't expect that to be the nature of my work"

Another believed that management were unconcerned which approach the therapists said they were using as long as a quick turnover of patients was maintained:

"But if they thought it was going to benefit them, and not impact on how long they would be in hospital then they would be quite happy"

Pressure to move on:

Some of the (physical) occupational therapists felt pressured by management to solve their patients' problems and move them on as quickly as possible using the shortest possible intervention:

"even if the person isn't that motivated you've got pressure to get that person out and they're coming back to you and saying " okay then, why isn't this person up and about and doing these things?""

Most described working under severe time constraints and pressure of work due for example to the size of caseload. The time available to spend with a client frequently therefore became a prime consideration when deciding on treatment approach:

"and as this is going on I'm thinking 'but I've only got 20 minutes here and I can't, we can't go into this'"

Invariably this meant 'doing for' the client:

"I'd probably jump several stages 'cos I'd be thinking well I've got 10 minutes then out so I've dealt with that now move on"

"the volume of referrals coming in means that you go out, you solve the problem as quickly as you can and then you move onto the next referral that's landed on your desk"

It appeared to be this influence from management which led to many to feel frustrated at being unable to provide a more genuinely holistic service, where they might work with clients on the underlying causes of their problems:

"There was talk of that being a bit of frustration, thinking " ooh if I had a couple of hours here I could start into things more deeply" "

Lack of backing to consolidation of training:

Two of the occupational therapists pointed out the illogicality of being allowed the time to attend the workshops whilst not being given the time to apply the approach in their routine clinical work:

"I find it interesting that they chose to allow my name to go forward for the CBT training and yet I'm not being given the backing to carry it on, so you will be aware of the hassle it was for us all to get to the training, so why did they take us out of clinical time like that if they're not giving us the clinical backing to carry on and do that?"

Unhelpful managerial compartmentalisation: Some of the medical occupational therapists expressed frustration at what seemed like an unnatural division of roles and responsibilities which led to an increased frustration at being able to offer a genuinely holistic approach i.e. a particular team is only allowed to look at certain issues or certain parts of the problem:

"I haven't really done anything for this patient but the powers that be seem to think if they are coming to day clinic even if she is getting physio here and I'm not really or I've not done fall prevention with her, the CBT thing is a completely different area"

6.6.3: Category 2: Encountering psychological barriers to the application of the training

Subcategory 1: Opening a can of worms

Many participants referred to fears that should they attempt to probe their clients psychological issues then they might uncover feelings or issues which a) they as therapists would not be equipped to resolve and b) would prove harmful to the patient.

"I was a wee bit worried in case I scratched the surface and got more than I could cope with"

"The worst case scenario I think would be where the result of the session was that they, left in such a state and I suppose you feel you've let them down, you've started to open up something and for whatever reason you couldn't finish, couldn't help"

Subcategory 2: Confidence issues

Many participants described feeling ill-equipped after 6 half-day workshops to begin to look in more depth at a patients psychological problems. They feared that they would be unable to respond appropriately to what the patient told them, or that they would get lost if their client deviated from the planned *script*:

"It's just as J said that I'm going to maybe start the conversation, and not know what to do with it"

"They might end up asking you "right so how does that go then?" and you wouldn't be able to answer"

Many simply described lacking confidence:

"And I think, I have to be honest with you and say that's partly why I would struggle to say it to patients, because I don't feel confident"

Some referred to fears that should they broach a CBT or psychological approach then they would leave themselves open to having to provide the patients with a level of explanation', which they felt ill-equipped to give:

"emmm...not to her, no I didn't because I'm not sure that wouldn't merit an awful lot of explanation to her"

Subcategory 3: Legitimacy

Some of the occupational therapists described the CBT approach as traditionally being the realm of doctors and psychologists:

"you associate it primarily with psychology don't you? Straight away you're thinking about doctors, thinking about the training that they do, 7 years training or whatever, it takes seven years to learn about CBT properly (laughs), so yeah, if you think about it that way it can be rather intimidating"

They made reference to the need for formal qualifications and years of training before they felt they could legitimately lay claim to formally doing CBT:

"I don't think that it would be scary, its just that I almost don't think I should 'cos you're supposed to go on like, what is it? Two years training? So how could I, why should I, say that when I've not done any training?, I've only done 6 sessions with yourself"

Because the physical occupational therapists traditionally worked to a focus on function and physical problems, they (not unreasonably) believed that their patients had come to expect this would be the focus for their work:

"Yeah, we work in uniform down here! (laughs) and that's typically what they expect, 'cos part of what I've already done for them is raise their toilet seat up and help them with their transfers"

They anticipated that patients or their relatives might become alarmed or defensive if the focus suddenly changed to psychological issues.

Subcategory 4: Unhelpful rules

Two participants expressed the belief that if they failed to secure what they saw as being an adequate resolution to the patients' problems in the course of the session they would have failed somehow:

"And there might be also this thing about well we haven't sorted it out yet, I'm a bit of a failure"

"or coming away from a session feeling like I had done with this person before on so many occasions that we didn't achieve anything on that"

This seemed to relate to the 'do for' ethos in the identity category i.e. the therapists were still operating on the assumption that it was their responsibility to 'fix' a patient's problems for them, and quickly at that! There was also the implicit assumption that this what 'proper' CBT therapists routinely do!

There was also evidence of a general fear of no doing the right thing:

"A disaster would have been to me of not having a reply ... I should have said this or I could have said that perhaps"

Similarly, the therapists felt pressure to 'get it right' before offering clients their opinions either verbally or as written formulations which they saw as being particularly daunting despite my emphasis in the teaching that these were not 'tablets of stone' and merely a way of drawing patients into the collaborative process:

" the formulations you presented they made perfect sense, seemed perfectly logical, and I could see that that would be of benefit to the patient, yeah maybe it is that, 'cos that's a very formal, well it's official and it's there and it's in black and white, and it's something that the patient/clients gonna see, so it has to be very very accurate and precise,.... there has to be good knowledge behind it."

<u>Subcategory 5: Anticipated resistance from patients/relatives/other staff</u>

"I think we are always wary of mentioning mental health, dementia, Alzheimer's, psychological things, because they are then going home and most of them are going to sit at home and worry"

"I think it would be "I'm not mad, I'm not mental " "I'm quite bright really, I've got all my marbles!"

Some described having to be extremely diplomatic in their choice of words, avoiding the use of terms such as 'psychological' and 'Cognitive Behavioural Therapy' in particular!:

"but if you were just to present them with "right okay I'm gonna CBT you today!" they're immediately going to think 'Oh Dear..'"

"I think it's just the word 'therapy' with 'cognitive-behavioural' put in front of it as well (laughs) but when you get a heading like that people tend to think of an analyst, you think of sitting on a couch, that's the kind of pictures that are going on in peoples heads and so yeah!"

Several therapists protested that overtly naming and describing the principals of any therapeutic approach was unnecessary and potentially off-putting to the clients:

"but to them the difficulty is that they can't do whatever, they can't get dressed or they can't drive their car that's what's important to them on a functional basis, it's not so important what the reason is behind it. The difficulty with CBT is what you're saying is the reason behind it is what you've got to really be thinking about"

The elderly population in particular was seen as being vulnerable to this reaction as well as being potentially intransigent to change:

"I don't think within the elderly they want to know exactly, they just want to be able to be the best that realistically they can be, so I don't know whether mentioning that it's psychological or whatever would make any difference"

Two of the participants described fears that should they be found to be trying a more psychological approach with clients that this would invoke suspicion that they were dabbling in areas which they shouldn't be from work colleagues (the patients GP in particular):

"I wonder why he (clients GP) keeps asking about me, he's obviously thinking 'just what on earth is happening here? will it work? Will it not work?'"

Another therapist worried that her client might challenge her legitimacy to be using CBT:

"I suppose my worry is someone coming back to me and saying 'well do you know what you are doing?'"

6.6.4: Category 3: Using strategies to overcome difficulties in applying the training:

Subcategory 1: Pragmatic strategies

This involved finding time to prepare for sessions, to rehearse or prepare 'speeches', read notes, to think about things, plan for eventualities i.e. what the patients might throw back at them as well as supervision:

"I mean some of the things we had for approaching "is this how you feel?" you know that sort of thing, I would like to have some of these things to hand and written out so we could read them legibly so I could say I knew what I was talking about"

It also involved looking at the environment in which the planned contact is to occur i.e. one therapist felt that addressing the patients' problems in the clinic setting as opposed to the patients' homes might make it easier to resist the temptation to simply 'do for' those patients:

"I actually wonder if it might be more difficult to see somebody in their own home, because I think seeing them here it's maybe easier, in a clinic to see our usual problems. Because I think the temptation from my own point of view might be to say 'c'mon we'll get into the car' if the car's at the door then the patient might think 'why am I not taking them shopping?' and I think from my perception it might be easier to look at it from inside the hospital setting as opposed to out with"

Simply having time to sit back and think about how they might plan their contact with the client was seen as crucial in applying what amounted to a 'new' approach:

"And it's also the time thing as T was saying to consolidated out thoughts and maybe have a go then think again about how could go on and what happened"

"but you need really an hour for a patient to get yourself organized, to get things set up right, especially to start, you'll probably need a couple of hours, so that you're..and almost rehearse your start speech before you start"

As well as what the participants ***did*** manage there was also an unfulfilled need here for further contact (clinical supervision) which most of the learners felt they would be beneficial:

"If I had, you know when you have an earpiece and you could prompt me (laughs) and I could sit with my patient and you could be telling me, coaching me, that's what I would like"

Subcategory 2: Psychological adjustments

One commonly used strategy involved reducing the perceived size of the task (and hence the dissonance between the therapists beliefs about their own capabilities are and the perceived demands of the CBT approach) They did this in a variety of ways including not referring to what they are doing overtly as 'CBT' so there was less expectation, less to live up to, less chance of being found wanting somehow:

"Me: "*So do you think not using the words 'cognitive behavioural approach' does that seem to help things?"*

" I think it helps me, yes just because I'm not looking, if I put it down in writing and kinda half expect somebody to come back to me and say 'Oh do you do that? Are you qualified?"

"emmm probably, yeah I would, I'd say 'look I'm not a CBT practitioner but I know a few of the techniques, I've tried them a few times, you know, I'd give it a go' sort of thing yeah certainly"

Some of the occupational therapists even shied away from framing what they did as 'tackling' an issue. This was seen as too 'strong' a term, preferring to frame what they did for example as being 'sensitive to' a patients psychological issues:

"I think being sensitive to the issue but I really don't think we had any idea on how to not tackle, tackle's too strong a word but y'know to approach or consider what that person was saying"

" whereas if go in "well maybe today we'll have a, just talk around some of the thoughts about some of the things that are going on at the moment and why this

is happening and why maybe you're feeling like this.." It's much more kinda personable approach"

Using a patient's own terminology and avoiding jargon wherever possible was a strategy used throughout every cohort followed-up in this research as a way of a) making CBT seem less threatening to the clients/patients as well as b) avoiding the perceived potential pitfall of the therapist 'setting themselves up' as in some way an 'expert' and therefore running the risk of not living up to a client's expectations:

"User-friendly language, I don't use jargon, I do in it as much sort of lay terms as I can"

"It's just a lot more comfortable speaking in a language that the patient will understand"

It was seen as less threatening to broach the issue of psychological problems such as anxiety if the client had raised the subject first:

"Me: But in a more general sense how would you sit down and say lets look at your anxiety? How would you feel about that?....
I think that would be okay, because she did acknowledge that herself in a way, she did mention it"

The therapists also tried to covertly develop any psychological agenda through the back door and also to use behavioural or pragmatic issues as a Trojan horse, i.e. a way in to deeper psychological issues:

"I think what the people would tell me because they expect a more physical approach is very much around the physical aches and pains but tell me a bit about this as well"

"I don't know that I would say psychological, I think we would just do what I did with this lady and say well okay, lets give me an example of what happened when you thought, when you woke on a really bad day well what was that bad day, what happened on that really bad day?"

An element of self-reflection or positive self-talk was also evident with some describing a process of challenging their own fears (for example not bringing a session to a 'satisfactory conclusion' or on reflection realising that something

had been missed) as being unfair and unhelpful (in effect self administered CBT!):

".... It wouldn't have been such a disaster, it wouldn't have been achievable or it would have been an omission rather than a disaster I think"

There was also evidence that some of the occupational therapists were aware of their tendency to prevaricate and of the need to simply 'take the plunge'. They described holding back from beginning to apply the training due to concerns about being in someway not good enough but were also aware that allowing themselves the opportunity to practice and refine skills was a necessary pre-requisite to developing confidence (and competence).

"I mean I think we a re probably being unrealistic ourselves in sense of feeling how are we ever going to have a sense of confidence with it if we never actually do it? And obviously through a period of learning we are going to have situations which we are going to be quite dissatisfied with and others that we think 'oh that's not too bad actually' but we have to actually get on with it, we're prevaricating"

Others described a process whereby they managed to overcome such unhelpful beliefs as 'I *should* be able to help everybody' by adopting a more realistic perspective and crediting the patient with a share in the responsibility for change. This was undoubtedly at least partly why they related so well to the collaborative ethos on CBT:

"what I very much find myself saying to this lady a lot is 'this is up to you, I have no expectations, I don't imagine that you will be independently going out in 6 months time, whereas for other patients we actually do set goals that say things like that"

A similar theme involved the therapists challenging their own beliefs regarding omnipotence and coming to terms with the inevitability that some patients would never engage in therapy despite the best efforts of the therapist:

"Yeah! I mean I feel fine, I think maybe it's my style or whatever but if someone's not wishing to engage now and don't want to work with me, that's fine, I don't have a problem with that"

Subcategory 3: Creating a sound therapeutic relationship

Here many of the occupational therapists described the need to build up a sound therapeutic relationship over time with their patients. This was seen as a necessary pre-requisite to broaching any potentially contentious issues such as CBT itself or moving away from a purely function focus to looking at psychological issues. The sub-category of Psychological barriers to application of the training 'Anticipated resistance from patients/relatives/other staff' is an influence here i.e. there is some fear that if things proceed too quickly they will encounter resistance from patients and therefore the stronger the relationship the more likely it will be able to withstand the potential stresses of introducing the psychological/CBT dimension.

"what I've been trying to do is I've arranged to see her a bit more frequently than I had been, really just to try to build up a bit more of a rapport with her, to then maybe feel a bit more confident"

"it took me probably 2 or 3 visits to get her to the stage of feeling confident to tell me everything about what she experienced"

6.7: Discussion

The themes which emerge from this study provide new insight into how occupational therapists actually experience the role confusion arising from occupational therapy's well documented struggle to establish its own identity.

A certain amount of apprehension will inevitably be present when trying out any new skills in the work environment. Self doubt and concern over ones competence is all normal and indeed functional. These occupational therapists however, described anxieties specific to the integration of a CBT approach within their own core professional identity.

They feared that broaching psychological issues with a client might well "open up a can of worms." The prospect of linking current issues to formative events in the clients past provoked the most apprehension. They described a fantasy whereby their inexpert probing of a client's psyche would cause the client

distress. They believed they would then be required to somehow resolve the client's distress there and then, a goal which they would be ill-equipped to achieve. If we were to examine these anxieties in a cognitive-behavioural framework certain 'cognitive distortions' suggest themselves. They could be said to be over-estimating both the likelihood and the severity of a feared event (a client in extreme and irresolvable distress). Furthermore they also appear to be devaluing or disregarding their own considerable professional experience when they imagine being unable to contain the client's distress.

An additional 'negative cognition' also suggests itself, namely the issue of responsibility. Included in the data are several references to a belief or schema that they *should* be able to reach a "satisfactory conclusion" at the end of each session. What this meant was that there should be tangible evidence that they have resolved some or all of the clients problems for a session to be deemed 'successful'. Inability to secure this was viewed as "failure". Anyone familiar with recognised psychotherapeutic approaches will be all too aware that such a 'rule' is profoundly unrealistic. Change or resolution in psychotherapy is usually gradual; setbacks are to be expected and change itself may be subtle.

This unhelpful/negative thinking centres around a theme which emerged in another of the main categories, namely *'reflections on professional identity'*. Most of the participants described having been socialised into a philosophy of working whereby they were required to *do for* their clients. Pressure of work meant that they frequently felt pressured to adopt the least time-consuming approach possible with this amounting to solving client's problems **for them** to achieve discharge or referral on. Adopting a psychological approach such as CBT with its less tangible outcomes and requirement for time to allow clients to explore issues created these aforementioned anxieties for the some participants

There is strong evidence therefore, that the participants were displaying (in CBT terms) 'dysfunctional assumptions' which could potentially act as a barrier to training transfer.

There was substantial evidence for further cognitive distortions:

One participant when discussing the prospect of offering a written 'formulation' to a client described unhelpful perfectionism i.e. the belief that any such formulation should be "formal" and be "accurate and precise". This contrasted to how a formulation was described during the teaching i.e. that the point of the

exercise was to draw the client into active collaboration and indeed **invite** them to critique, revise and refine the therapists ideas.

Fear that broaching a psychological approach might result in their being asked difficult questions by the client or their relatives which they had no answer for, was described several times. The underlying belief which influenced this anxiety, was that their legitimacy to explore psychological issues was, at best, suspect. They therefore feared in effect, being 'found out'. Once again this could be framed in terms of an under-estimation of themselves and an over-estimation of the danger or threat from their environment (their clients/relatives).

This issue of legitimacy also emerged in the context of how particularly the physical occupational therapists anticipated their colleagues might react to their focussing on psychological issues. One expressed concerns that a GP whose client she was attempting to address certain psychological issues with was becoming concerned that she was dabbling in areas she should not be. Again, given that there was no direct evidence that this was in fact what the GP was thinking, her anxieties may well have been a product of role dissonance.

The central issue of role dissonance emerged elsewhere in the data. The belief was expressed by some that CBT was associated more strongly with psychologists and psychiatrists, seeming to suggest that occupational therapists have a sense of their own professional identity, what is legitimately within that and what is outside. One believed that patients associated CBT with "analysts and sitting on a couch". These examples again indicate a dissonance between how the occupational therapists see themselves and the daunting fantasy of what 'legitimate' CBT therapists look like.

A final source of concern for the participants was connotations associated with CBT itself. Some felt that it implied an overly technical approach which their clients would a) not understand and b) act as a barrier to engagement. A standing joke in the class was the (very genuine) belief that should they overtly suggest "cognitive behavioural therapy" to their clients then those clients would run a mile!

These themes, where stress is located within the therapists' own psyche, have already been described in the occupational therapy literature (Tan, 2004). Although Tan frames the unhelpful/irrational beliefs in a rational emotive

behaviour therapy (REBT) context (Ellis, 1997) as opposed to a CBT one, there is significant overlap between the two paradigms particularly regarding the centrality of irrational beliefs. Tan described occupational therapists as displaying the most irrationality with "self-directed shoulds" which mirror exactly the findings here i.e. that they ***should*** be able to draw the session to a successful conclusion, that they ***should*** be able to say or do something to alleviate the patients distress, that their formulations ***should*** be completely accurate.

6.8: Conclusions

This study develops Tan's earlier work on irrational beliefs, framing those beliefs in a cognitive behavioural framework. It also illustrates the influence of role dissonance as a potential contributory factor in the origin of those beliefs. As in Tan's study, the occupational therapists did not display any "extreme irrationality". Given however that these beliefs are shown to act as a potential barrier to training transfer, it is hoped that the findings from this study will be taken into consideration in future training events, allowing occupational therapists training in CBT to reflect on and perhaps challenge their own unhelpful thinking styles and thus better facilitate training transfer.

Chapter 7: Discussion of findings and main literature review

7.1: Introduction to the chapter

The purpose of this chapter is to review the findings and understanding to emerge from this research and to locate these within the context of the existing bodies of literature across the various relevant subject matters. This will show how the findings from this study are both informed by and in turn might inform this extant literature. There are two distinct sections within this chapter. Section 7.2 is the main or substantive literature review which in an emergent grounded theory study such as this follows after the analysis of the research data. In section 7.3 consideration will be given to the inclusion of the occupational therapy study and the Diploma CBT respondents within the study as a strategy to enhance the completeness and depth of the study as a whole.

7.2: The substantive literature review

7.2.1: Introduction to the section

This section of the chapter contains the main literature review for this study. Given that this study employs a qualitative methodology, specifically grounded theory, it is therefore an inductive process whereby the theory which accounts for and frames the research data emerges only once the analysis is complete. Working within this paradigm it is therefore impossible to carry out the main literature search at the beginning of the study as per a scientific or logico-deductive study as at that stage of the research process it is not yet known which literature will be relevant to the study.

The aim of this section will therefore primarily be to identify existing literature directly relevant to the understanding and theory to emerge from this study, to locate the findings from this study in the context of this extant literature, and finally to analyse how the findings from this study add to or develop this existing knowledge base in terms of new knowledge.

This literature review is organised into five headings which represent the academic subject matters which have the greatest relevance and overlap with the research findings from this study:

7.2.2: Training Transfer
7.2.3: The political and historical context of the nurses' experiences
7.2.4: Personal and professional identity
7.2.5: The history and experiences of nurses training to deliver psychological interventions
7.2.6: Counsellors, psychologists and psychotherapists' experiences in training

The subjects discussed in sections 7.2.3 and 7.2.5: *The political and historical context of the nurses' experiences* and *The history and experiences of nurses training to deliver psychological interventions* respectively, have already been discussed in terms of how they contextualise this study in the *a priori* literature review contained in chapter one of the thesis. Their subsequent inclusion here in the substantive literature review allows for a fuller exploration of how the findings from the *analysis* phase of this study relates to these subject matters.
The actual location of this study however, lies in the overlap between these five headings. The five headings represent established areas of academic research/interest which are all directly relevant, but no one in itself can legitimately lay claim to encompassing this study within its own corpus. The location of this study within the subject matters discussed in this main literature review is therefore best represented by the following diagram figure 1 overleaf.

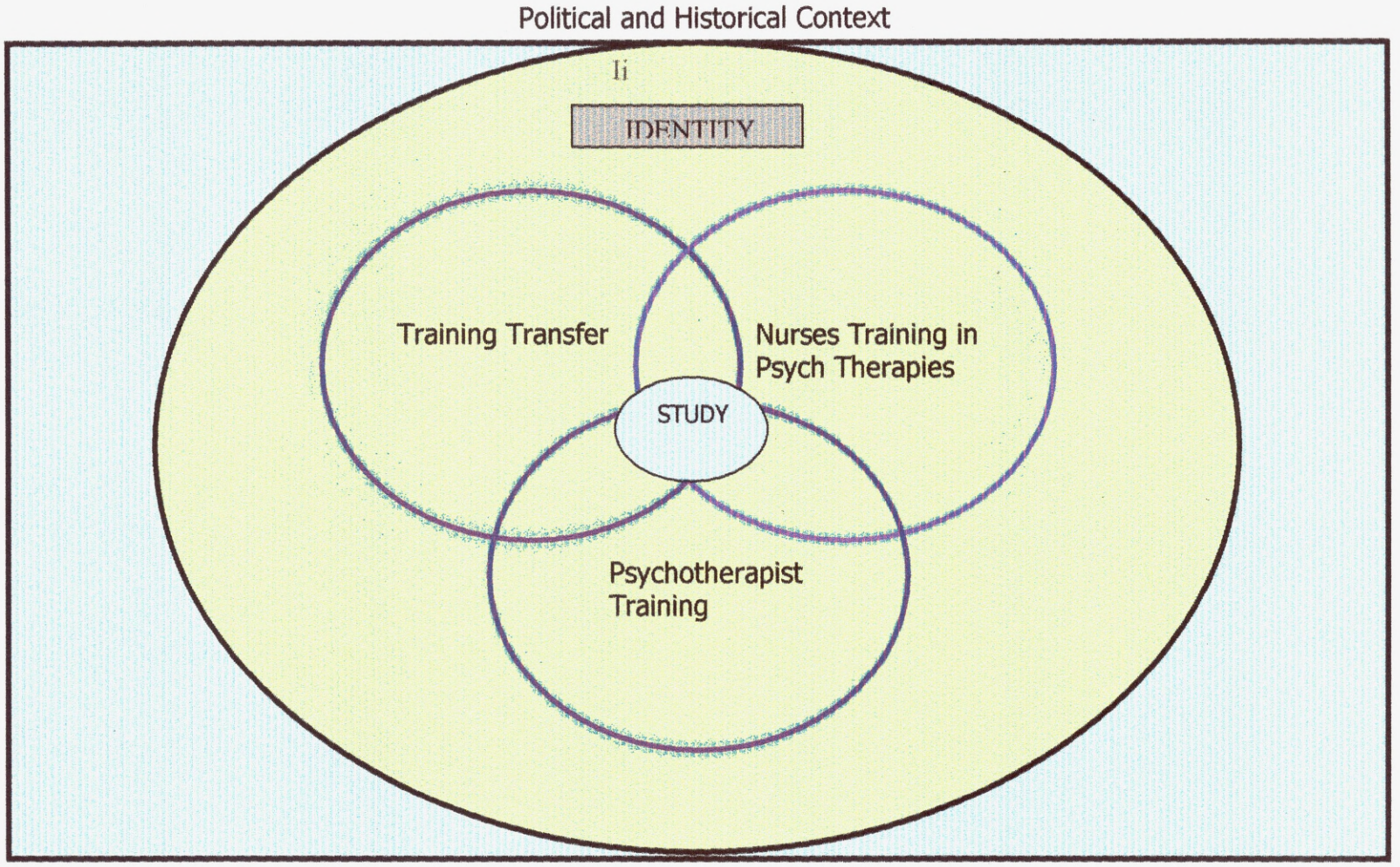


Figure 9: Diagrammatical representation of the relationship of the main literature review headings to the study

7.2.2: Training Transfer

7.2.2.1: Introduction

The main focus of this study concerns the experiences, primarily of nurses, who are attempting to apply what they have learned in a continuing professional development (CPD) intervention to their routine clinical work. A central theme of the study therefore becomes the transfer of training. There already exists however, a body of academic knowledge which is located across the boundaries of several subject matters and disciplines yet collectively can legitimately be considered to come under the unitary heading 'Training Transfer'. Given then that there is already a body of extant knowledge directly relevant to the phenomenon under examination here, then it is clearly imperative to review this work and consider how it might inform the findings from this study.

This section therefore will describe how the knowledge created in this study relates to the broader field of training transfer or as it is sometimes referred to 'transfer of learning'. I will provide an overview of the field including a definition of the term training transfer, briefly highlight the foremost studies and their main subject matter, describe how the results of this study can be conceptualised in terms of three key issues from the training transfer literature namely generalisation, motivation and 'transfer culture' and finally consider how the understanding generated from this study might add to and enhance the existing body of knowledge in this field, going some way to address some of the gaps in the literature and areas highlighted as requiring further research. One key area from the research, which has been identified as having a potentially significant impact on the degree of training transfer, is the type, quality and appropriateness of the training itself. This study will not however directly examine that issue given that unlike much of the training transfer literature, this particular study is not primarily concerned with the analysis of the strategies best employed to maximise transfer, rather the main focus here remains that of understanding the experiences of the research participants/trainees themselves.

7.2.2.2: The Field of Training Transfer: Its location and a review of the literature

Training transfer and its attendant literature is located across a variety of disciplines, primarily: educational psychology, business management studies and human resources. There are numerous definitions of the term with perhaps the most concise being found in Baldwin & Ford (1988, p.63) namely "*the effective and continuing application in the job environment of the skills and knowledge gained in a training context.*"

Training transfer is traditionally seen to be a sub-field of training literature in general, covering training design, practice, research and evaluation. Several texts have highlighted the concern however that research specific to the issue of training transfer itself has been "*perfunctory*" at best (Haskell 2001, p.77) with Shoobridge (2002) stating that whilst there has been an explosion in training research literature it is only recently that the research has turned to the transfer of training problem. This clearly mirrors concerns expressed specifically from within the fields of nursing and healthcare CPD, that vast budgetary and time resources are being provided without adequate consideration of the impact of that CPD on clinical practice. (Oxman, 1994, Jordan, 1998).

Two of the most frequently quoted volumes on training transfer are: Broad & Newstrom (1992) and Haskell (2000). Both cite the enormous cost of training estimated annually at $53 billion in the United States alone (Foxon 1993) and the convincing body of evidence that as little as 10% of the training actually transfers to the workplace (Baldwin & Ford, 1988) as reason why the issue is of such global importance. Clarke (2002) draws attention to the fact that evidence of training transfer in what he terms as *human service organisations,* of which healthcare trusts are examples, is particularly scant, a situation which he quite reasonably points out is unsatisfactory given that such organisations rely primarily on the performance of the staff they employ for their effectiveness.

The Broad & Newstrom and Haskell publications offer however somewhat contrasting accounts of the field, perhaps reflecting a shift in emphasis over the intervening eight years between their publication dates. The full title of the Broad and Newstrom (1992) work is: *Transfer of Training; Action packed Strategies to Ensure High Payoff from Training Investments.* This title offers a

strong clue as to the actual tone and emphasis of the book. The two key issues explored are environmental/organisational barriers to training and strategies which might be employed before, during and after the training to maximise the likelihood of transfer and thus maximise likely return from financial investment. The overall tone of the book is behavioural, frequently referring to potential reinforcing and inhibitory factors and citing the overall goal of any training/CPD as being to improve performance of the individual, and by extension the organisation itself. One of the most telling paragraphs (Broad and Newstrom 1992, p.27) states: "*...we view manipulation as the examination and control of key variables surrounding the employee so as to induce and maintain desirable behaviours. The goals are legitimate within the organisation, and both cues and reward systems can be made known to the employee.*" Despite that final and rather half-hearted proviso, it is clear that trainees are viewed as components in an essentially reductionist/mechanistic system, a common theme throughout much of the training transfer literature.

In contrast, Haskell (2000) at least begins to consider such themes as personality, motivation, meaning and emotion and their relation to the issue of transfer. He suggests that "*significant and general transfer is primarily the consequence of personality and other dispositional characteristics such as "attitude, motivation and feeling"* (Haskell, 2000, p.116) His account of these issues however rarely extends to the domain of the specific. He discusses a concept called "*The Spirit of Transfer*" at some length, cites research which concludes that a positive affect instilled in the trainee can enhance learning and describes how deep learning which has some intrinsic or *felt* relevance to the trainee is more likely to result in training transfer. He also acknowledges the likelihood that transfer of training a social context whereby the unspoken, or at least the unwritten norms of the work environment interact with individual characteristics to facilitate of inhibit transfer. Despite Haskell's book adopting a slightly more humanist approach than Broad and Newstrom, neither are able to escape from the limitations of broad themes or generalised taxonomies primarily focusing on the needs of the organisation/employer as opposed to the experiences of the trainee which are left largely unexplored. There is evidence however of a shift in emphasis in both the methodology and the research focus of more recent training transfer enquiry with Clarke (2002) including useful

qualitative data, which something of a rarity in the training transfer literature, in a study into how work environment and organisational factors influence training transfer. Pidd (2004) in addition, applies a social learning perspective to the field and suggesting that a trainee's individual interpretation, the meaning which the training transfer situation holds for him/her, should be considered when planning such training.

I would suggest therefore that the research conducted for this thesis potentially complements and provides a useful addition to these recent trends in the training transfer literature by offering a rich and detailed description of a specific training situation and most importantly of how the trainees in that situation socially construct their own realities and the impact of this on their training transfer experience, to an extent mirroring the androgogic or student-centred learning philosophy of Rogers (1980) increasingly adopted today by higher and further education institutions.

7.2.2.3: How the Training Transfer literature informs the findings from this study

There are themes in the training transfer literature which will allow the reader to better understand certain issues which arose from this research. Four of these will be addressed here in detail, namely: generalisation, motivation, the culture of transfer and relapse prevention.

1: **Generalisation.** It was highlighted previously in this study that there is a dearth of evidence within the fields of CPD in nursing and related health professions that CPD interventions teaching psychological interventions made any real difference to behaviour in the clinical area. This is however quite different to stating that it has no impact, rather it has proven hard to demonstrate the effect. Foxon (1993, p.131) offers a plausible explanation as to why this might be. Reviewing the literature on evidence for transfer of training she finds that evidence is particularly lacking "*with training in conceptual, judgmental and cognitive skill areas, such as problem solving, management development, and interpersonal skills training where trainers admit they have no firm proof that the training impacts the way employees do their jobs*". CBT is

unquestionably a concept or model of approach which from my own twelve years of experience of working as a specialist in the field, varies quite considerably in its application from therapist to therapist and even with the same therapist across different cases. It is an individually tailored application of broad principles some of which have shared commonality with other approaches such as person-centred counselling or cognitive analytical therapy. It is not a procedure which can or should be replicated or repeated exactly as taught. It is a continual series of judgement calls by the therapist. Foxon's description of those kind of broad, variable situation-specific skills where measurement is particularly problematic appears therefore to describe exactly those skills and behaviours common to CBT.

Clearly then these kinds of skills are difficult to measure, which may go some way to explaining the absence of studies in the literature. This application of learning across varying clinical situations, some inevitably differing profoundly from examples used in the training is a theme explored in some depth in Haskell (2000) who uses the metaphors of generalisation, equivalence and analogy to locate specific training transfer issues within the broader context of reasoning on the basis of prior learning. His findings are that the greater the degree of generalisation required from the training then the harder it is to both achieve and demonstrate transfer of training as compared to for example replication of a simple procedure. However Haskell also concludes that this ability to generalise indicates a deeper, more authentic level of transfer and should ultimately then be actively planned for when designing training. If one revisits the quotations from the transcripts in the results chapter of this report and follow their assimilation into progressively more conceptual structures, it can be seen at the core, the story of the research participants endeavouring to adapt what they have been taught across different roles, different environments, apply to different client/patient groups, differing management expectations, different clinical guidelines and so on. It seems reasonable therefore to surmise that there is an extremely high level of generalisation required by the research participants in this study in order that they might apply what they have been taught to their clinical practice and that this therefore may be one of the key underlying reasons why there were such a broad range of training outcomes from no attempt to apply the teaching to examples of fairly successful integration of a

CBT approach into routine clinical work. It also offers an explain for the overall rich descriptions of post- training mental and emotional activity where the research participants are clearly trying (borrowing a phrase from schema theory) to accommodate and assimilate new learning not only within internal structures but also within external constraints, influences and limitations. I would assert that this mental and emotional activity is evidence of the research participants' efforts to generalise their training.

I would suggest in summary that given the kind of skills being taught to the research participants in this study, along with the hugely varying work environments they find themselves in, it is completely unrealistic to expect simple replication of teaching under these circumstances. The data gathered during this study, at its core more than anything else reflects this attempted transformation/generalisation. My own opinion is that even the phrase 'Training Transfer' may be a grossly over-simplistic label to attach to a far more subtle and complex process.

2: **Motivation.** Motivation of the trainee not surprisingly perhaps, has been identified as one of the key determinants of the likelihood of successful training transfer Shoobridge (2002). Taylor (2000) considered trainees to be unlikely to apply their training when they lacked motivation or if they had poor attitude. The rather general term 'motivation' is better operationalised in Foxon (1993), who uses the term 'transfer intention' to describe trainees' end of course motivation to apply the training in the workplace. Initial levels of motivation across the four cohorts who comprise the research participants from this study **for attending** the training was subjectively extremely high given that a) the participants were essentially self-selecting, volunteering to attend the workshops, some forgoing lunch breaks and others even attending in their days off and b) there was no direct reward consequent to the training, such as promotion, financial reward or even a certificate of attendance, other than the potential benefits of the training itself. Transfer intention at the end of the course was assessed through the taped transcripts. Analysis of this data shows a slightly more complex picture, which varied across the different cohorts according to their individual circumstance. Statements to the effect that CBT was a highly useful intervention which could bring clear benefits for patients

were commonplace across the four cohorts. In the cohorts containing the occupational therapists and the more generic nurses, the enthusiasm for the approach was somewhat tempered by a gradual realisation of the reality of trying to apply the CBT approach themselves in their clinical practice, remembering that this data was collected after the course once the research participants had returned to their clinical areas. Time constraints, lack of confidence, inappropriate patients, competing demands of higher priority clinical issues, role conflict and lack of management support were all cited as reasons why direct application of the training might prove to be problematic. Some research participants showed evidence of manipulating the CBT taught in the training by reframing it as a CBT "*ish*" approach with others stating an intention to apply only specific parts of the model. It seems reasonable therefore to conclude that motivation is in itself no guarantee of successful training transfer. Although the purpose of this study was not to formally assess the ***extent*** of training transfer, the evidence suggests that in common with multi-factorial models of training transfer such as Thayer & Teachout (1995), behaviour change will be influenced by a ***combination*** of factors, some inhibiting and some supporting and each with magnitude and direction. Reviewing the data from this study it seems likely that the main supporting factor for behaviour change with these research participants is motivation and their initial belief in the relevance of the training content. A change appears to have taken place however between the research participants' identification of an unmet need for their clients/patients and initial well-intentioned motivation to attend the training, and the position which they found themselves in at the end of the training when the realities of transforming that training into actual clinical practice had began to dawn on them. The barriers to change which are highlighted in the results section of the thesis and are also discussed below under the heading *Culture of Transfer*, as per the model described earlier in Foxon (1993) act in concert as a net inhibitor to training transfer, effectively tempering that initial enthusiasm/motivation. The fact that in the follow-up interviews, many research participants clearly describe applying their training, albeit to varying extents and having performed various manipulations and transformations on the original training material to adapt it to their own circumstances, demonstrates that their initial motivation has in effect carried

them through some difficult obstacles, remembering that none of the participants were in any way obliged to apply the training and were not going to be evaluated by management or supervisors. Pidd (2004) offers an alternative, highly apposite perspective on the influence of motivation in training transfer situations by exploring the role which identification with the organization has to play in the process. Pidd confirmed the findings from other studies that the support of supervisors was usually a positive influence on training transfer (Roullier & Goldstein, 1993; Smith-Jentsch et al, 2001), but found that this could in fact be contingent on the degree to which the trainee identified with the organization or smaller group. Framing his findings within social identity theory (Bar-Tal, 1998), Pidd's hypothesis that where identification with the group was strong then supervisor support would improve training transfer and likewise where identification was weak then supervisor support would have little impact on training transfer was confirmed. These findings appear to have direct relevance to this study, particularly in the relative experiences of cohort #1 and the other three research cohorts. Cohort #1 was the only complete homogenous group within the study in that they were a newly formed team with their own identity and an obvious sense of unity, cohesion and purpose. That was also the only cohort where there was genuine, active supervisor (and peer) support. Although this is not a comparative study, it was clear from the data that cohort #1 were the most successful in transferring what they learned from the CBT workshops into their clinical practice. Applying Pidd's findings to this phenomenon it is clear that individuals in cohort #1 not only had supervisor support, but were also motivated to conform to the normative attitudes and behaviors of their group including the supervisor. The other cohorts had neither the direct supervisor support nor any real identification with a group or organization where there was a normative pressure to comply with (in this instance) applying CBT training to clinical practice and so were found to be less motivated to actually apply their training. The research participants in these cohorts instead retained identification with those organizational sub-groupings within which they worked i.e. nurses or occupational therapists and indeed that may partly explain why despite the offer of clinical supervision from myself to these cohorts they either declined or did not subsequently make contact with me to arrange this. Two final influences on motivation which have both been

identified from the training transfer literature also appear to be of direct relevance to the experiences of the research participants from this study. Clarke (2002) reasonably suggests that the absence of any formal expectation or assessment from within the organization that training will result in behaviour change along with the perception of any such training as being for personal development i.e. not for career development or enhancement of employment opportunities, may well diminish motivation for applying the training. Both of these conditions were true for the research participants in this study who, as stated earlier, were under no obligation or expectation from their managers/supervisors to apply the training from their managers/supervisors, even in cohort #1 this was not at all explicit, and most clearly stated that their motives for attending the training were that they had identified either a skills deficit in themselves or an unmet patient need thereby corresponding to Clarke's (2002) interpretation of the term *'for personal development'*.

3: **The culture of transfer.** This is a term coined by Pea (1987) to describe the sum of the total group and social influences on transfer. Haskell (2000) echoes the symbolic interactionist approach adopted throughout this study when he asserts that the goals, meaning and significance of learning and transfer are inevitably defined socially, determining which elements of a situation or problem are important to attend to and which are not. Haskell and many others (Mosel, 1957; Richey, 1992) highlight this culture of transfer as being one of the key determinants of training transfer. Given that pre-training motivation among the various cohorts of research participants (as measured by their self-selection etc) can reasonably be assumed to have been fairly constant, and also taking into account that the training content and format across the groups was broadly similar, it is logical to examine more closely how the 'culture of transfer' may have been a significant variable in determining the type and extent of training transfer. It has only been through reviewing the training transfer literature for the purposes of this report that I have become aware of how profoundly atypical the CPD which I have been providing is in comparison the typical examples cited in that literature. Perhaps the most effective way to illustrate this is to view a typical model of training transfer and its role in business/industry namely 'The Sheffield System' as described by Analoui

(1993). This model locates CPD or training in the context of identified symptoms or problems within a workplace for which training is devised to change the behaviour and practices of staff, as means to address or resolve the problem or address the identified need. Fundamentally, the need for the training, the type of training required, who shall be given the training and how it shall be evaluated is identified and determined by management to address their concerns or identified needs for the organisation. The circumstances surrounding the delivery of the training central to this study, as described in the introduction to this report, were however for a significant proportion of the research participants sampled for this study, entirely different. Cohorts two and three responded as individuals to 'flyers', which I had distributed to different departments within my healthcare trust, offering the opportunity to attend workshops on CBT and inviting them to contact me directly for further details. I then informed them that the training was contingent on sufficient numbers, usually a minimum of six and a maximum of 12 participants, identifying themselves as being willing and able to attend and that we would coordinate the workshops as far as possible around their schedules, beginning when I had secured sufficient attendees. Prospective participants would then inevitably have to approach their line managers and request study leave. Cohort four was slightly different in that an occupational therapist who had attended the third series of workshops suggested to me that many of her colleagues would be interested in the training and suggested that I meet with her line manager to describe the training and leave similar flyers to make available to her staff. The occupational therapists who responded to this became cohort four. In effect then, the training for those participants in cohorts two, three and four entirely circumvented the usual influence of management. Managers were made ware of the training, allowed myself to distribute the flyers within their departments and ultimately sanctioned the time required to attend the training. The crux however is that they did not identify a need for the training, they were not aware of a problem or issue that having a staff members equipped with CBT skills might resolve and nor were they looking for any specific changes in the behaviour/practice of their staff in the workplace as a consequence of the training. These training interventions became to all intents, a direct contract between the participants and myself. Cohort one however was somewhat

different. This was a group of nurses from the same newly formed team, who had been recruited specifically to deliver short-term psychological interventions to a client group defined as having mild to moderate mental illnesses. Both the direct manager of the team, who herself had a clinical role and attended the training, and her line manager had heard about the possibility of training beforehand, and had actively requested that they might attend in order to satisfy a clearly identified skills deficiency which they felt that CBT training could address. The goals of both the cohort themselves, and their managers that this training was intended to be applied directly to their clinical role as a core component of their practice and would be supported accordingly. This then was a very different scenario from the other three cohorts and in that respect it can be said that the relative cultures of transfer between cohort #1 and the others were profoundly different on that key dimension of management/organisational involvement and support.

I believe that the critical difference between the groups post-training experiences can be best framed again in relation to the aforementioned Sheffield Model. In that model, a problem or a need is identified solely by management and training is commissioned accordingly to meet that need. In cohorts 2, 3 and 4 it is the participants themselves who identify a need, typically to feel more equipped to address the psychological dimension of their patients' problems, and seek the training to address that need. In examining the different post-training experiences of the two types of cohort, there is more evidence of direct application of the CBT training in cohort #1, along with less role ambiguity or conflict and less concern that they might be perceived with hostility or questioned about their role by others. In cohorts 2, 3 and 4 concerns are frequently raised regarding how employing a CBT approach might clash with their perceived role identities. Unlike those in cohort #1, most do not actually try to, or feel able to practice what might legitimately be described as CBT after the training, instead more commonly they try to use **broad principles** from the training within their pre-existing roles, or apply individual parts of the model.

My interpretation of these differences is that the culture of transfer for cohort #1 had been better primed to facilitate transfer of the training. Management had identified a need and had communicated that need to the participants, creating an expectation that they would use the training. Dedicated time was also

provided for reflection and peer support. For the other three cohorts the culture of transfer was significantly different. Management had not identified a need for the training, there was no expectation the training would be applied and there was no post-training support which might have facilitated transfer. Clarke (2002, p.152) in his study examining those factors which influenced training transfer in a public sector social services department found similar evidence that the *culture of transfer* had not permeated as far as the workplace and in common with the research participants from this study found that "*the nature of workplace constraints meant implementing the training was prohibitive*" although he did not specifically use the term. In common particularly, although not exclusively, with the occupational therapists' experiences from this study, the participants in Clarke's study found in essence that their workplace simply did not afford them sufficient time and space to implement new practice. As one research participant in this study put it:

"*To try and take on CBT and be recalling what we had done in the workshops, trying to access notes, think about where the information was on notes, I would have found very difficult, I couldn't do it that 6 months, I think because the pressure of work and also too, yeah the pressure of work is one thing but battling with your own self is the other half, because you know that you're out of control etc, so it's all kinda psychological, your own psychological packages couldn't have taken on anything new*"

A sentiment which resonates strongly with this following quote from a participant in Clarke's (2002, p.152) study:

" There was a bit too much of it really, too involved, too complicated. Unless you read it all through. There's too much of it...I've never actually used the [skills]...Personally I'm still in a learning situation, so I wrestle with things all the time and to me this is complicated, particularly as I work with the elderly and there are huge numbers..."

4: **Relapse prevention.** One concept from the training transfer literature which has direct relevance to this study and is indeed adapted to conceptualise the product of the action research cycle in the conclusions chapter of this thesis is that of relapse prevention. Although relapse prevention was initially a the name given to an approach used to prevent cocaine addicts from relapsing after

treatment, Marx (1982) adapted it for educational purposes, supporting transfer of training by looking to prevent relapses to old ways of working. Marx (p.438) described 14 'strategy groups' designed to facilitate training transfer all of which were essentially designed to anticipate and then sidestep potential obstacles to training transfer, including surprisingly "*reduce emotional reactions that interfere with learning*" and "*retain self-confidence after making temporary errors*" both of which appear to at least acknowledge the importance of the cognitive/emotional barriers to change as highlighted in this study although the focus of the relapse prevention approach throughout the occupational psychology literature remains very much focused on environmental or situations blocks to training transfer (Tzinier et al, 1991).

The specific focus of this study has been on the influences of identity and role dissonance on transfer of learning. Accordingly, the modifications planned as part of the action research cycle were designed to take account of these very issues. There appears therefore to be a very comfortable overlay between the action research component of this study and the concept of relapse prevention now widely described within the training transfer literature. The concept of relapse prevention would appear to both give validity to, and provide a better framework for understanding my own endeavors within this study to anticipate and address some of the problems of transfer. For example an occupational therapist might experience discomfort when trying to broach the subject of her client's apparent psychological difficulties due to the both the therapist's and her client's assumptions about role. This effectively takes the therapist to a threshold or crossroads where they might choose to proceed with the approach or instead adhere to previously establish norms of core practice. Relapse prevention in this instance might involve anticipating the situation, exploring the cognitive basis for the distress and looking at examples of how other learners have overcome such role dissonance, hopefully facilitating the application of skills and knowledge gained from the training. The difference between the application of the relapse prevention approach in this case in contrast with the various examples cited in the literature, is that the potential blocks and barriers being inoculated against are not environmental or situational but instead are cognitive, emotional or attitudinal. I would assert however that

there is no reason why the relapse prevention approach should not routinely be adapted to include these factors.

7.2.2.4: Section conclusions

The literature reviewed in this section has provided an account of the field of training transfer and allowed for consideration of how the phenomenon described in this study might be better understood within the context of the extant theories/knowledge specific to that field.

It is now appropriate to summarise what might be learned from the field of training transfer in terms of how future CBT training might best be delivered.

Returning to the somewhat anomalous, atypical nature of the CPD in this study as described earlier, and how it in effect bypassed normal managerial/organisational influences, when planning for future, similar training events I clearly have an obligation to learn from these insights. Any such future training would have to be located more directly within needs identified by management and as part of formal, strategic CPD planning rather than an interesting but ultimately anomalous 'add-on' existing far too far outwith the participants and their managers usual milieu to have a realistic chance of real impact. It would only be by doing this that the necessary supervisory and peer support as described previously in this section could be ensured and the *culture of transfer* maximised. The concept of relapse prevention (Marx, 1982; Tziner, et al 1991) has, as described earlier been shown to enhance training transfer by encouraging learners to anticipate potential environmental difficulties in applying their training and pro-actively planning strategies to overcome these difficulties before they encounter them. It is this author's belief that the use of this established strategy but instead adapted to address internal, cognitive and emotional barriers to training transfer offers a novel and useful addition to the existing approaches to maximize transfer of training.

7.2.3: The location of this study within the historical and political contexts of the nurses' experiences

In section 1.4.4 of this thesis an account is provided of the background historical and political influences which contextualise the research participants' experiences in this study. The picture emerges of an unprecedented expansion of the nurses' role, a development which on the surface appears to be willingly embraced by the majority of the profession.

Several studies however have illustrated difficulties in the developing of extended roles for community mental health nurses, and these appear to be highly relevant to the themes and issues which have emerged from this study.

Expansion and extension of the traditional nurse role is often seen as a positive or an opportunity (Garbett, 1996). Many nurses have willingly embraced the challenges of developing new skills and greater autonomy (Rosen, 2002) and the very fact of the publication of Scope itself is a powerful indication the direction the nursing profession at its highest level envisages for itself. This is clearly supported by the data from this study, which paints a picture of nurses enthusiastically volunteering to undergo training to develop new skills and an expansion of role. Some researchers however have viewed these developments with trepidation, cautioning that a dilution of the core nursing role at the expense of intrusion into other roles might lead to a profession in something of an identity crisis (Hoover & Oojen, 1995). This theme of inevitable fracturing of role is picked up in Brown et al. (2000) and in Basset & Corrigan (2002). Other researchers have taken things a step further and described how the extended role of the nurse might actually lead to conflict with other professions. Dingwall et al (1988 p.144) anticipating the changes ahead, felt that the move into community and multidisciplinary settings had left the profession "*threatened by encroachment from other professions, particularly social workers and psychological therapists.*" Griffiths (2001) suggested that community mental health nurses (CMHNs) would encounter ideological conflict with other healthcare workers over who is best suited to provide care for the patients, Barker (1998) describes problems with boundary issues for CMHNs and Nolan identified a problem for CMHNs in how they define their own roles as distinct from other health care professionals.

The themes of role dissonance and anxieties about applying their training, which the many nurses in this study have described, appears to reflect in microcosm the concerns and issues described above in the wider profession. The research participants, whilst retaining an enthusiasm for CBT, nevertheless express concerns regarding the legitimacy of describing what they do as 'cognitive behavioural therapy' they worry about living up to their own expectations (albeit overly idealistic ones) of how other professions might deliver psychological therapies. They anticipate resistance from clients and carers who they believe have fixed expectations of what parameters a nurse should conform to, interpret queries made regarding their practice by other staff as indicating concern or suspicion, and fear that they themselves are simply not sufficiently skilled to adopt the new role. What can be seen therefore is perhaps the first description of possible internal barriers to role expansion. The literature as described earlier in this section focuses on the political and historical dimensions to expansion/extension of role but does not adequately explore the potential meaning of such changes for the individual. The, if not unique then certainly unusual, aspect to this study is that all the participants have a choice as to whether or not to apply the CBT training to their clinical practice, and if they do, then in what form. It can be seen from the research data that these issues of role dissonance can act as barriers to role expansion when individual choice is present. It is hypothesized elsewhere in this discussion that if there is more of a managerial/organizational backing for CPD such as this, with an overt expectation of change, then it seems logical to suppose that such concerns of legitimacy and role dissonance might be at least partially assuaged. However, this study has provided a deeper understanding of how, on a more individually constructed basis, deeply held concepts of role identity might be challenged when nurses are asked to expand their roles as part of this ongoing paradigm shift in healthcare provision. If role expectations and professional boundaries are not clarified and if sufficient training and follow-up supervision is not provided to allow the nurse to feel safe in their new roles then it is likely that barriers to change similar to those described in this study will have a negative impact on nurses' willingness and ability to take on these new roles.

7.2.3.1: Section conclusions

The research participants from this study find themselves in a situation which is in effect, a reflection in microcosm of a process/phenomenon which is occurring at a national level driven by social and political imperatives, and for the most part is being embraced enthusiastically by the profession itself.

These new roles and responsibilities which nurses are being encouraged to adopt however necessitate both individuals and the profession as a whole to reflect on how they define themselves as nurses, consider what, if any, their core identity might be, and also how they relate to other professions in terms of overlap and separation of role. Some of the studies cited earlier have begun to caution that this inexorable expansion of the nurses' role may lead to potentially problematic fracturing of identity and conflict with other professions.

The experiences of the nursing research participants as described in this study offers a valuable insight into a dimension of these challenges faced by the profession which has been relatively neglected thus far by the literature. The cognitive and emotional consequences of role dissonance as described in this study, suggests that nurses might struggle to fully embrace the opportunities being opened to them by the removal of barriers to the expansion of role unless more attention is paid to clearly defining the boundaries and extent of our professional practice and backing that up with the necessary educational and organizational infrastructure.

Interestingly, the separate occupational therapy study, which is included elsewhere in this thesis primarily for the purposes of validation through triangulation of subject groups, describes an almost identical phenomenon. Occupational therapy, for different reasons, is also a profession that has often in recent times attracted the term 'identity crisis' to describe its sense of professional cohesion. The parallel experiences of both the nursing and occupational therapy research participants in this study when considered in the context of the national situation suggests that we are in fact at a key transitional point in the demarcation of roles and responsibilities within the health care industry as whole.

7.2.4: Personal and Professional Identity

7.2.4.1: Introduction

The process at the centre of this study reflects a requirement for partial transformation of the research participants' sense of professional identity if they are to apply the CBT training in their clinical practice. From a core identity of mental health nurse or occupational therapist, the research participants must somehow accommodate and assimilate knowledge and skills which can be considered to be outwith that core identity. It must be stressed that after a mere six half day sessions of CBT training it is unreasonable to expect any profound or fundamental change in identity, rather the research participants, if they are to successfully apply the skills taught to them in the workshops, are required to expand their core repertoire of behaviours and therefore the boundaries of their professional identity in order to accommodate the new role.

The new knowledge and skills when taken in isolation are more commonly associated with different groups of healthcare professionals such as psychologists or clinical nurse specialists. The tensions which the training (or more accurately any attempts to *apply* the training) places on the participants' core professional identity and the issues of dissonance which arise therein, are at the hub of this study. The participants find themselves having to define, re-evaluate and then in some cases challenge the skills and behaviours they feel they can legitimately carry out as part of their established professional identity before they reach what they have defined as being their professional limits and the beginnings of another profession's sphere of legitimacy such as psychologist, therapist or nurse specialist.

It is therefore necessary in this section to review the literature pertaining to how identity in is defined and constructed both in general and with particular reference to the concept of professional identity in nurses. Given also that the core process reflected in this study appears to describe tensions within and challenges to that sense of core professional identity for the research participants, it is also appropriate to explore how these themes manifest themselves within the modern nursing profession as a whole. It is a further aim

of this section to consider how the research findings from this study may both inform and be informed by this body of knowledge.

7.2.4.2: General theories of identity: Mead and Erikson

One of the earliest writers to address the issued of identity was G.H. Mead (1934). Mead located the formation of identity or identities in the conduct of social activities and relationships and also in the symbolism of the language used in these everyday encounters. Mead and those who followed him understood identities to be multiple according to the different roles and social settings which the individual found him or herself in. Accordingly one's important identities might variously include nurse, nightclub musician, father or political activist. Although Mead initially preferred the term 'self' to that of 'identity', by the 1960's the latter term became the most widely adopted in common usage. This theoretical school later became identified as 'symbolic interactionism' (Blumer, 1969) and shares its basic premise with the grounded theory method used within this study, namely that meaning is constructed through social interaction. The symbolic interactionist approach to identity is in essence that identity is a social construct just as the self is a social object where the individual can act towards him/herself as he or she does to others. Identity is therefore not fixed and instead is constructed according to how the individual derives meaning through interaction with others and the self in the context of the various roles which one inhabits.

Erik Erikson (1950, 1959, 1968) offered a perspective on identity which although of equal historical and scientific status with Mead's seminal work, differs fundamentally in its concept most likely due to Erikson's background as a psychoanalyst rather than a social scientist in the tradition of Mead and Blumer. The Eriksonian concept of identity is, unlike Mead's, an overarching one, interrelating the individual's sense of self to the major dimensions of life. Eriksonian approaches attribute significance to achieving a coherent and consistent identity that continues over the course of one's adult life. Central to Erikson's theory is the concept of the 'identity crisis'. Erikson viewed the central task to identity development as that of developing a sense of personal sameness and historical continuity. He believed that although adolescence was

the time when most individuals were likely encounter the phenomenon, such a crisis could develop at ant point during an individuals life when they found themselves at risk of losing that sense of personal sameness and historical continuity.

7.2.4.3: The use of Meadian and Eriksonian concepts to conceptualise this study

Although the two theories differ significantly in emphasis, Mead's focusing on the means by which individuals form multiple senses of identities in relation to roles, status, and cultural persona and Erikson's stressing the importance of overcoming obstacles to achieving a stable single identity that is the integration of an enduring and consistent self in social life, both appear to have relevance to the experiences of the research participants in this study.

The term identity as used within this study relates almost exclusively to the research participants' professional identity, how they define themselves purely in their role as nurse or occupational therapist and so seems to lend itself well to a symbolic interactionist interpretation in that the focus is on how just one of many identities is constructed through reciprocal interaction with others in adjacent roles (colleagues, managers, patients etc). Holland et al (1998, p.30) go on to describe how in the Meadian or symbolic interactionist scenario, "*identities are culturally constructed social types, social and cultural products that are actively internalised as self-meanings (treating one's own behaviour reflexively as symbolic) and serve as motivation for action. People identify themselves with (and against) actors in particular domains of their lives*". This description resonates strongly with the many examples of reflexive self-contemplation of the research participants as described in the 'reflecting on boundaries' subcategory from the results section of this thesis where the nurses are in effect asking themselves: 'what does it mean to be and how should I act as a nurse?' The key concepts here are those of self-authoring where the research participants actively construct and interact with internal as well as external influences on identity and also of motivation for action which arises out of the reflexive debate, in the case of the research participants leading to either the decision either to progress or not to progress the CBT approach in their

work depending on its congruity with their concept of behaviour and values appropriate to nurses.

One of the main themes to emerge from this study however is that of role dissonance where the research participants experience psychological discomfort and struggle to accommodate the demands of the CBT role within that pre-existing sense of professional identity. This is almost suggestive of an mini-Eriksonian identity crisis whereby the research participants (to a lesser extent cohort #1) when faced with the prospect of practicing what they have learned in the workshops, experience a challenge to their sense of continuity and sameness, coming up against the realisation that they will have to at least partly redefine how they perceive their role identity. Holland et al (1998, p.29) suggest that an Eriksonian identity crisis is characterised by the need to find answers to such questions as: " *Where, with whom, do I belong? Am I (are we) good? What is my (group's) place in society? Do I (do we) deserve respect? Am I acceptable as a person? Am I true to myself, whatever the situation?*"

Again, glancing through the direct quotations in the results chapter of this thesis it is quite striking just how similar the questions quoted above are to those regularly being asked by the research participants in this study.

Both the symbolic interactionist (Meadian) and Eriksonian perspectives on identity as described above suggest that there are critical times in our personal and professional lives where demands can be made on our sense of identity. These demands inevitably cause us to begin to ask questions of ourselves. Holland et al (1998, p.29) sum up nicely when they consider: "*Do they (the questions) come (unbidden) from within or from questions and challenges lodged by dialogic partners? Are they psychogenetic or sociogenetic or both?*"

What they are asking in effect is, are these identity issues driven primarily by social or psychological factors? If it is the former then a symbolic interactionist approach to their study is more apt. If it is the later then Eriksonian analysis is more appropriate.

As evidenced by the studies reviewed later in this section, the literature as a whole seems equivocal as to the answer to this question. Accordingly my own preference is to use both approaches pragmatically according to their individual utility.

The context and focus of the data obtained for this study in reality only affords the reader insight into how the research participants experience and define their identities as nurses or other health care professionals. There was no direct access though the research data into how the research participants defined themselves as individuals prior to or outwith the development of their professional identities, nor into what personal value systems they brought with them to their work or how these were shaped by more general social influences. Accordingly, for the purpose of theory building and action planning in the action-research phase of this study, the symbolic interactionist perspective on identity is more useful for what amounts to the bottom-up aspect of the research. When one is required however to adopt a conceptually higher level perspective on the issues and themes arising from this study, then the Eriksonian perspective is valuable due to the descriptive richness and broader context it provides the reader.

7.2.4.4: A review of the literature relating to identity within the nursing profession

A review of the literature on identity in nursing reveals a body of work which is arguably as diverse and fractured as the profession itself. There are studies which locate themselves strongly within a specific geographical or national context, Canadian nursing in the case of Boschma et al (2005) or Japanese nursing (Gregg et al, 2001). Many studies adopt a gender perspective, male nursing in the case of Holyoake (2002) or gender stereotyping (Jinks & Bradley, 2004). Some studies combine the concept of identity with that of self- concept and link these issues to power relations with other professions (Roberts, 2000) or self-esteem and equality of professional status (Arthur, 1992). Studies exist which examine the influence of different grades of nurses on identity (Mackenzie, 1996) and inevitably some studies look at the identity of individual specialisms within nursing (Beal et al, 1996; Leishman, 2004). Ethnicity as an influence on nurses' identity is well represented in the literature (Yoder, 2001; Henly et al, 2006) as is the influence of pre-registration training on socialisation into a nursing identity (Du Toit, 1994). There are also studies which attempt to

differentiate the identity of mental health nurses from their general counterparts (Moir & Abraham, 1996).

There have however been studies which have attempted to explore more global themes in nurses identity. In a review of the literature Fagermoan (1997) identifies three common themes through which nurses identity are frequently conceptualised namely: Professionalism, perceptions of the nurse role and moral values. Although these may appear similar at first glance, Fagermoan differentiates them thus; Professionalism is used as a framework in a social context to communicate to self and others the value of a professional status. Moral values are held to be the foundation on which socialisation into a sense of professional identity rests via a reciprocal process of interaction between the nurse and his/her (work) environment. These values then translate into an action orientation which has a patient's well-being at the core of the nurses range of behaviours. Perceptions of the nurses' role is more about defining oneself as a nurse by what one actually does, the role content.

This is clearly a symbolic interactionist perspective where the meaning inherent in these three themes forms part of a reciprocal interaction between the self and those who the individual shares the social world of nursing with, socialising them into a sense of professional identity. Significantly, these is evidence from this study that all three of these core influences on the research participants sense of identity are in some way challenged by the demands of potentially incorporating the CBT approach into their routine work. The concept of professionalism is clearly not a unitary or absolute one. The evidence from this study suggests that professionalism is instead a relative concept. Several of the research participants when questioning their validity to use the CBT approach used the term 'professional' to describe other disciplines with a more specialist, psychological role from themselves, suggesting their perception was that they as generic nurses felt somehow less professional than those other groups.

The second theme which Fagermoan identifies, perceptions of the nurses' role, has perhaps has the most obvious relevance to this study. Throughout the data there is evidence that research participants are being forced to reflect on the historical norms of their role, the limitations, defining characteristics and inter-professional boundaries which exist and again are both being brought into focus and crucially, challenged by the new demands of applying the CBT training.

There was convincing evidence from this study to support Fagermoan's assertion that his third theme, 'moral values' plays a key role in defining nurses' identity and again these values appear to be challenged by the central task under consideration in this study. The most illustrative quotation from the data is from two community psychiatric nurses from cohort four who were discussing their feelings regarding the exposure based treatment of panic disorder as it had been taught during the workshops. The CBT approach to panic disorder is very much that the patient has to relearn that their fears and their physical symptoms of anxiety are not going to culminate in some catastrophic end-point such as death or fainting or going mad. This is achieved by encouraging the patient to tolerate their increasing anxiety until their symptoms begin to abate of their own accord. I recall several sharp intakes of breath from the class at the time of the workshop and was not surprised when two of the research participants raised the issue during a subsequent joint interview. They expressed discomfort and unease at the prospect of not doing anything to alleviate the patients distress explaining that their nursing identities instinctively made them want to do something for the patient, to remove their suffering: "*I would definitely say that if it was me, I'd be terrified to see them in that state and I would find it difficult if I was stuck in the middle of the high street with them I would panic for them because I would think 'oh! this is horrible' you know, you're exposing them to other people looking at them and you know that would be difficult for me*".

The two nurses have clearly been socialised into a value system (for which caring in this instance is a perfectly reasonable shorthand). That value system appears to contribute significantly to their sense of professional identity or who they are and was clearly challenged by asking them to alter their behaviour. However the paradox is that although the nurses' presentation appears to demonstrate a caring value based moral system, the clinical evidence would suggest that the exposure-based approach which they are reluctant to apply is actually the more likely to benefit the patient.

A concept such as 'nurses' identity' must somehow differentiate itself from the identity of other professions. There has to be some unique condition, quality or function over and above a mere job title in a contract of employment, which defines the individual as a nurse as opposed to an occupational therapist or a doctor for example. Accordingly, much of the literature on nurses' identity has

sought to capture what Clarke (2006, p. 389) describes as "the essence of nursing".

Several studies have returned to the aforementioned theme of values, suggesting that nursing has at its core a value system, which may confer a certain uniqueness of identity across the various branches, specialisms and sub-divisions of nursing. That core value system is often summarised as 'caring' (Watson, 1988; Benner & Wrubel, 1989). Ross (1998) elaborates, describing caring as 'a locus of unity' with the purpose of "the restoration and/or enhancement of rational autonomy (in clients) the occurrence of which: constitutes a single qualitative end that is equally applicable in the treatment of broken limbs as it is mental disorders" (p.183). Fagermoan (1997) operationalises the term caring to better describe how the term translates into actual nursing practice as well as has already been discussed, looking at how the process of socialisation into an identity also incorporates socialisation into a common value system which guides both behaviour and self-concept in other words the nurse as moral agent. The term used in Fagermoan's work to describe the moral underpinnings of caring is "*other oriented values*" (p.439). Within these values the concepts of altruism, preservation of human dignity and a holistic perspective on the uniqueness of the patient and his/her problems strongly feature.

Staking a claim to a uniquely caring or value –laden moral 'backbone' as one of the defining themes in a global nursing identity is however an extremely perilous position to adopt. In order to justify such a claim one would be required to qualitatively judge or even quantitatively measure, the attitudes, values and behaviours towards patients/clients of nurses and every other healthcare professional from doctors to chiropodists for whom directly caring for patients was a key component of their job and prove in some way that nurses "*cared more*", a position rightly ridiculed as being untenable in Clarke (2006). The quote from Ross (1998) cited previously and offering a definition of the caring approach which is presented as a 'locus of unity' for nursing identity could equally be presented as a description of the value system for mental health physiotherapists, occupational therapists or doctors. Clark also goes on to further attack the importance of caring in itself as a morally desirable condition upon which a profession might ground its identity. He argues that the fact that

the nurse 'cares' is less important than **what** the nurse cares about and how that care manifests itself in behaviour, essentially echoing the paradox at the centre of the panic disorder example from this study, cited earlier. Would a patient prefer a nurse who clearly cares about him/her yet for example takes a long time, causing pain and bruising when administering an injection or would that patient prefer a nurse who says little, is quiet and efficient yet is able to administer the injection skilfully with the sensation of the merest pinprick?

A second broad theme in the literature offers a different suggestion as to what condition, quality or function might be the central theme in how nurses' identity is constructed and differentiated from other professions: Possession of a body of knowledge or being able to define a discrete theory (or theories) of nursing can give nurses a sense of professional identity which allows them to define the unique contribution which they make in the field of health care. (Colley, 2003). Abbott (1988) suggests that a well-developed abstract knowledge system is key to any professions potential success in establishing a clear identity for that itself which might allow it to compete with other professions on an equal basis. Donaldson & Crowley (1997) further link professional identity with knowledge base stating: " *a discipline is a community of interest that is organized around the accumulated knowledge of an academic or professional group*" and in Colley (2003) a unique body of knowledge is listed as one of the key requirements for nursing to consider itself to have distinct professional status, and by implication for nurses to attain a coherent sense of professional identity. The problem however with attaching identity to a discrete body of knowledge which the profession and therefore the individual can call his/her own and define what he or she does accordingly is that it is highly debatable whether or not nursing actually does have a body of knowledge to call its own. Monti & Tingen (1999) describe a long-running and still unresolved debate within the nursing profession as to which paradigm should guide nursing science, empiricism or interpretivism. It can be argued therefore that nursing is still unable to decide what constitutes knowledge never mind what knowledge it should lay claim to as its own. Callery (2005) argues convincingly that since nursing research cannot lay claim to a methodology uniquely its own, it would be more accurately re-classified under healthcare research. The long-standing

but uneasy relationship which nursing has with medicine is also a factor here. Gerrish et al (2003) in a study looking at masters level nurses, highlight how the increased skill levels of such nurses are in fact framed in terms of knowledge and practices more closely associated with those of doctors, suggesting their increased professionalism was achieved through encroaching closer to areas previously associated more with medics. Similarly, a cursory glance through any university pre-registration nursing degree program will instantly recognise modules on sociology, psychology, biology, pharmacology, ethics, law and so on. It can be argued that the introduction of models of nursing in the late 20th century was an attempt by the profession to define itself through a clear framework, allowing for the translation of nursing theory into practice. Inevitably however, as described in Colley (2003) the number of different models and the conflicting emphasis within each only added to the confusion, with for example Roper, Logan and Tierney's (1980) model of nursing attracting criticism for relying too much on the medical model and Peplau's (1952) for ignoring basic physical needs.

Both attempts therefore to define nursing in terms of either a value driven/moral stance that is human caring, or in terms of its supposed unique body of knowledge are therefore at best only partially successful. One is left with the impression of a profession which may simply be too diverse, too fractured across dimensions of specialism, geography, gender, educational status, time and political whimsy to ever lay claim to a unique position within the healthcare services. The implications of this for the possibility of any coherent or cohesive sense professional identity of individual nurses are profound. 1. The quest for a discrete professional nursing identity and the consequent requirement for some kind of cohesive, meaningful definition of that identity is not just an interesting abstract academic pursuit. 2. Role blurring and confusion over a coherent sense of who nurses are, or indeed who they are not, professionally has been shown to have detrimental effects on the psychological well-being of nurses and other health care professionals who find themselves in a similar situation (Fullbrook, 2004; Leonard & Corr, 1998). At the heart of the problem is a dichotomy between the educated, professional, technically competent practioner which is increasingly held up to be the gold standard by today's nurses and the more traditional caring role which has somewhat fallen out of favour. The former role

also becomes the stereotype which nurses both aspire to and are encouraged to emulate in order to satisfy modern professional and educational demands, and therefore asserts a profound influence on identity.

The latter traditional caring role which Gerrish (2003) suggests is in danger of being forgotten in the drive to compete on an equal footing with other professionals with the attendant risk of alienating a public who greatly value those humanistic qualities. Dingwall & Allen (2001) describe how holistic emotion work is viewed by healthcare managers and planners as a luxury and how many of those core patient care activities are now being delegated to support staff who are usually unqualified.

A study which concisely sums up these competing tensions in nursing's 'identity crisis' is that of Johannessen (2004) who looked at a group of Norwegian nurses who were also practitioners in alternative therapies and how their practice as alternative therapists impacted on their professional identity as nurses. Johannessen describes how modern values of productivity, efficiency and scientific rigor along with the increase in bureaucracy, the tendency towards specialisation and the dominance of the medico-scientific model are fundamentally at odds with the caring, holistic and empowering, somewhat feminine approaches which have traditionally defined nursing. The nurses interviewed for Johannessen's study rather than describing a conflict between the role/identity of the nurse and the role of the alternative therapist as might reasonably be expected, actually felt more authentic, truer to the philosophy and identity of what they believed nursing should be like when they practiced as alternative therapists in contrast with their work within the Norwegian health service based on the biomedical tradition where they described their practice as being closer to carrying out a supportive function for biomedicine and doctors' work rather than actual nursing. They described how their work as alternative therapists allowed them to spend time with patients, to use therapeutic touch, and to genuinely practice, and not just pay lip service to, a holistic approach.

Johannessen clearly adopts an Eriksonian view of identity in her study by stressing the importance of the integration of a personal value system with those which nurses bring to their clinical role with patients. She tellingly suggests that "*Being a nurse largely means using oneself therapeutically*" (Johannessen 2004, p.49) a statement which has very little resonance with the previously described

modern vision of nursing with its emphasis on scientific knowledge and technical competence. Johannessen's study in effect describes a profession at a crossroads, struggling to satisfy two seemingly contradictory demands i.e. to satisfy the increasing demands of consumers for holistic approaches which value the individuality of the patient above all else and the demands from education, politics and from within some sections of the profession itself, to achieve professional recognition and status by competing with other professions to demonstrate academic and technical parity.

7.2.4.5: Implications for this study

As mentioned earlier, the training provided to the research participants in this study appears to place demands on their sense of core professional identity. Those who do successfully go on to apply the approach appear to be able to somehow, to borrow a phrase from schema theory, accommodate and assimilate the new, extended role within their concept of what a nurse is. Those who are unable to take this on board experience role dissonance and cope with this by deciding not to progress the CBT training into their clinical work.

In revisiting the theme of nursing laying claim to a discrete knowledge base as a core component of professional identity one is forced to re-examine this teaching of CBT to nurses as part of this study. Can CBT be considered to be part of a unique nursing knowledge base? Given that it is also practiced routinely by clinical psychologists, psychiatrists, occupational therapists and psychotherapists the answer would appear to be no. Equally significantly in considering some of the statements made by the research participants in this study e.g. *"I suppose it's like the borderlines between your job, nurse/therapist/OT you know, all these different things, you know, the traditional borderlines, I think that's where it comes from, the nurse does nursey things and that doesn't include being a therapist..."* then it becomes abundantly clear that some nurses do not consider CBT knowledge or practice to be part of their core identity.

It has already asserted elsewhere in this study that this dissonance between nursing identity and the perceptions of what a CBT role involves is the cause of uncomfortable feelings such as anxiety in many of the research participants with

a corresponding impact on their behaviour such as choosing not to or only tentatively applying the CBT training in their clinical work. If one revisits the literature on identity issues from social psychology, then it is possible to frame the situation the research participants here, find themselves in terms of the two main previously mentioned extant theories symbolic interactionism and the Eriksonian perspective. Erikson considered the achievement of a stable, consistent and enduring self-concept to be one of the main psychodynamic tasks necessary to achieving psychological well-being. He described the individual as trying to develop and maintain a core identity, which would fundamentally remain consistent across different social situations. One path to achieving this end was considered to be affiliation and allegiance to a culturally identifiable group.

Erikson went on to suggest that when individuals experience "self-discrepancies" between contexts then the consequence is psychological distress. In this situation the research participants have clearly identified strongly with the group 'nurses'. The task of applying the CBT training necessitates at least partial allegiance with the values and norms of practice more associated with other social groups e.g. 'therapists'. My task as an educator, hoping that students will apply their training, therefore becomes to better align and identify the principles and practices of CBT with more commonly held nursing values and practices which nurses in training might better recognise as their own. Broadly speaking, cohort #1, the Primary Care Liaison team, appear from the data to have embraced the CBT approach, post teaching, more completely and with less identity based anxieties than the other three cohorts. It seems reasonable to suppose that this is a consequence of their having fewer competing and perhaps incompatible demands being made on their sense of identity in comparison to the generic groups or ward or community based nurses and occupational therapists who still have to contend with a great deal of social pressure from colleagues, managers, and patients to conform to the expected norms and values of their given social identity namely a 'nurse' as appears to emerge from this research. The primary care liaison team appear to have been able to re-align themselves into a discrete social unit with its own identity, a clearly stated occupational remit and interestingly no mention of the terms 'nurse' or 'nursing' in the title, therefore ameliorating any external sources of

dissonance. The other three cohorts can be seen to be struggling to maintain the coherence and continuity which Erikson attaches so much importance to being expected to function, at least partially, using an approach which in terms of knowledge base, values and practice is significantly different from that of nursing.

Although it is not cast in terms of Eriksonian identity issues, the article "*The rhetoric of rupture: Nursing as a practice with a history?*" (Nelson & Gordon, 2004) nevertheless addresses the above mentioned issues of identity in the wider context of current political and social influence on the profession of nursing in a way which can easily be framed in terms of a warning re the potential stresses of the demands being made of the nursing profession to embrace multiple identifications. The authors highlight issues raised recently by other researchers (Gerrish, 2003; Arthur, 1992) pointing out that nursing as a profession is constantly reinventing itself to satisfy political, social and educational demands and also perhaps in an effort to improve its own aspirations towards professional legitimacy and equality, blurring the boundaries with neighbouring professions such as medicine rather than remaining true to a core sense of identity. Nelson and Gordon caution that by doing this and abandoning continuity with our history nurses run the risk not only of devaluing ourselves as a profession but also of alienating and disenfranchising those nurses who find themselves unable to join the technical elite. In terms of the research participants in this study it is possible that I have fallen into that very trap in that my attempts to equip them with the means to deliver CBT, or at least 'CBT type') interventions, has unwittingly placed strain on their ability to maintain a consistent identity across contexts through too crude an application without sufficient consideration of these issues. Returning to the symbolic interactionist idea that self-formation is a reciprocal process between the individual and his/her social/cultural context, the problem might be summarised by suggesting that in the conditions within this study, certainly in the case of the three 'non PCLT' cohorts that the reciprocity required for re-socialisation is impossible given that whilst the research participants were hopeful of and motivated to change there was no corresponding flexibility or accommodation from the social and cultural context within which they operate namely their wards or community teams etc.

7.2.4.6: Section conclusions

In this section it has been demonstrated how the identity related concerns of the participants in this study have their origins in issues and concerns already highlighted in the nursing literature at a national and international level. There is pressure on, and indeed desire by, nurses to expand their role, taking on responsibilities previously exclusive to other professions and in doing so enhance their own professional status. There are dangers inherent in this however. Nurses carry with them an unspoken and perhaps unconscious allegiance to a particular set of historical values which largely define who they are. The public too, recognise and identify with these values, which can be broadly summarised as 'human caring' with the profession of nursing. It is far beyond the remit and boundaries of this study to suggest how the profession as a whole might develop and grow, as it surely must, yet at the same time remain faithful to its roots as a compassion driven, patient focussed vocation. This study has gone some way to confirming the fears voiced by others that if nursing does not manage to successfully negotiate the dilemma then the resulting identity related problems can have a negative effect on nurses' psychological well being in situations where identity is challenged. It also confirms that these issues must be considered when planning any significant CPD event in order that the implications for any hoped for transition are better understood and more thoughtfully managed.

7.2.5: The location of this study within the context of the history and experiences of nurses training to deliver psychological interventions

In section 1.4.5 of this thesis an outline was provided of the existing studies detailing the experiences of nurses providing and being trained to provide psychological therapies. The experiences of the research participants as described in this study appear on the one hand to confirm the findings from the existing studies described in that section, particularly the existence and inhibiting influence of environmental barriers to training transfer, but also perhaps more importantly, they suggest a gap in the existing research which

although is directly relevant to the issue of training nurses in psychological therapies, has not yet been fully explored.

The action research component of this study has already been presented earlier in this thesis as a means by which the difficulties and experiences of earlier cohorts can be understood and learned from, allowing these lessons to be integrated into the training of subsequent groups to pro-actively improve their chances of overcoming potential barriers to change. Milne (2002) describes a relapse prevention approach to the problem of training transfer in a study into nurses training in psychosocial interventions, which has strong parallels with the action research component of this study. In his study however, Milne does not base the content of his relapse prevention module directly on the experiences of previous groups attending the same training, rather he utilises a general model of relapse prevention (Marx, 1986) which originally was applied to management development and not nurses training. The use of a generalised relapse prevention module also precludes any real possibility of incorporating identity-based concerns or context-specific references to internal barriers such as unhelpful thinking in all but the broadest terms into the content of the module as the experiences of management trainees will have no relevance to the lived experiences of nurses training to deliver psychological therapies. Accordingly the relapse prevention module in Milne's studies is limited to the consideration of these aforementioned environmental barriers to training transfer.

These environmental/organisational barriers to change, which the participants describe in this study, are duplicated in almost every other similar study.

The conclusions reached by Paley et al (1993) and Fadden (1997) have particular relevance to this study. As I have already described, with the exception of the first cohort, the primary care liaison team, all the training delivered to the other three cohorts took place in complete isolation from managerial or organisational structures, was not part of any staff development plan, and nor was it initiated in response to any needs identified by management for which it was felt training might offer a solution. It would be fair instead to describe the training as essentially a contract between the research participants and myself to which management gave their passive approval. Cost-free training which some staff are prepared to attend in their own time proved to be quite popular with line managers. Unfortunately as several studies described earlier

have demonstrated, there has to be significant corresponding organizational accommodation to allow the space for the trainees to practice and develop their newly taught skills, there has to be management support and consideration has to be given to which patients the trainees can begin to apply their training with and what the expected outcomes will be. In most cases in our study this simply did not happen. Accordingly, all the environmental barriers to change described in the above mentioned studies such as insufficient time, lack of support, lack of suitable patients, conflict of priorities among others, were also described by the participants in this study. Corrigan (1997) suggests that for this kind of training to be effective then the whole team should attend the training. Again with the exception of the PCLT in cohort #1 the reality in this case was that one member of a ward, community or day hospital team would attend the training before returning to a mildly curious but unchanging work environment.

The second issue to emerge from this review of the existing literature on nurses training in psychological therapies is what these other studies have not described, what I believe thus far has been a neglected focus for research. This is the role which identity plays in mediating the transfer of training and also how internal barriers to change, framed in this study as unhelpful cognitions, exert a powerful influence on the process.

Some of the existing literature does *hint* at these issues: Corrigan et al (1992, p. 139) cite *'philosophical opposition'* as a barrier to nurses implementing behaviour therapy training. They expand this term into three factors: belief that behavioural therapy does not work, belief that it is inappropriate for patients and finally that behavioural therapy is unethical. Although this at least begins to look at internal mediating factors i.e. values and attitudes there is no qualitative development of these themes and the *philosophical opposition* is confined to the trainees' beliefs about behavioural therapy. There is nothing in the paper about the other half of the equation, namely how they view ***themselves*** as opposed to the training. Milne (1984) does draw attention to the benefits of any training course having what he terms as "social validity". This again however stops short of a fuller consideration of the concept of "social validity" for example, how the nurses' sense of professional identity and concept of role might influence the validity of the training for them. The relapse prevention module instead limits itself to an exploration of the benefits of a patient-centred, pragmatic course as

opposed to a more didactic traditional classroom one. Fadden's (1997) paper describes a lack of confidence as being one of the reported barriers to implementation of a behavioural, family therapy training program. Although the mean difficulty score for these issues is only 0.88 on a five-point (0-4) scale, it nonetheless confirms the findings of this study that internal issues such as confidence are a significant barrier to training transfer. Once again however there is no attempt to explore this 'lack of confidence' any further.

The findings from this study strongly suggest that the nurses' identification with primarily a nursing identity as opposed to for example a *therapist* identity can lead to dissonance when attempting to apply elements of the CBT approach which the nurse believes to be incongruous with the nursing role/identity. This in turn acts in effect as an internal barrier to training transfer when the nurse is motivated to reduce that dissonance by deciding not to apply some or all the taught CBT skills. Similarly the discovery of related negative and unhelpful cognitions centred around the themes of either anxiety or legitimacy can further negatively impact on training transfer by resulting in the behavioural consequences of avoidance or procrastination. The proposed modification of the relapse prevention module to address these internal issues of cognitive and identity based obstacles to training transfer by incorporating many of the implicit strategies devised by the research participants themselves (as discussed in detail in chapter 9 of this thesis) offers those providing CBT training to nurses and other generic health care professions in similar environments the potential to apply these findings to their own training situation and in doing so optimise the chances of meaningful transfer of skills from the learning to the clinical environment.

7.2.6: Counsellors', psychologists' and psychotherapists' experiences in training

7.2.6.1: Introduction

The aim of this section is to review the existing literature regarding the experiences of counsellors, psychologists and psychotherapists in training. In particular, the emotional aspects of their experiences are held to be of particular relevance to this study.

experience of training to become what can loosely be described as a health care professional. The research participants in this study were embarking on their CBT training having already gone through an equivalent process of socialisation and development into the roles of nurses or occupational therapists. It has already been shown that the resultant role dissonance is a core theme in this study which will not therefore be commonly repeated in the literature reviewed here. However, a great many of the concepts and understandings described in Ronnestad & Skovholt's model, particularly in the novice/student stages of development, clearly have direct relevance to this study.

Orlinsky & Ronnestad (2001) note that the experience of anxiety amongst novice therapists is a common one across nationalities as well as therapeutic orientation. Skovholt & Ronnestad (2003) draw further attention to the potential impact that a therapist's anxieties can have on his/her ability to work effectively with clients, in effect being unable to attend fully to their clients due to the competing demands of having to either attend to or suppress their own anxious thoughts as well as having to cover up any observable evidence of their anxieties lest their clients pick up on this, in effect paving the way for a cognitive-behavioural formulation of the process. Skovholt & Ronnestad's observations regarding the impact which trainee therapists' anxieties can have on performance effectively mirrors the cognitive-behavioural conceptualisation of the research participant's difficulties described in this study and illustrated diagrammatically in figure 8a. Where they stop short however, is in not explicitly describing the consequences of the interaction between thought, emotion and behaviour, which is the self-reinforcing '*vicious circle*' familiar to all CBT therapists. The key point of this is that that the anxious thoughts lead to problematic excesses or deficits of behaviour, trying too hard or avoidance respectively, which then create problems which reinforce therapists' negative beliefs about themselves in a self-fulfilling prophesy.

Most of the themes concerning the research participants' anxieties and difficult feelings, which have emerged from this study, are reassuringly echoed in Skovholt and Ronnestad's work as well as that of other researchers.

The experience of feeling overwhelmed was a common one amongst the research participants in this study. In a quote from Skovholt & Ronnestad's (1995, p.27) study, a participant complains: "*At times I was so busy thinking*

It is once again important to stress that the research participants in this study are not counsellors, psychologists or psychotherapists in training, nor are they being trained to carry out equivalent work. However, the theories and understandings contained in this body of literature, particularly relating to the very early stages of their training, are highly relevant to the experiences of the research participants described in this study and throughout this section the reader will recognise corresponding phenomenon in each.

A major theme to emerge from this research has been the origins of the anxieties and doubts experienced by the research participants when confronted with the task of attempting to apply something of what they have learned from the training in face-to-face contact with their patients/clients. Of particular interest has been the underlying cognitive basis for these feelings. As has been evidenced, the closer these attempted interventions are identified by the nurse/therapist with CBT as a formal concept, then the greater the potential for anxiety. The work reviewed in this section of the main literature review adds significant value to this study in two ways: Firstly the conceptualisations of the research participants' experiences described in the results chapter of this thesis are confirmed and supported by the findings of the researchers referred to throughout this section. Secondly in the work of Thomas Skovholt and Michael Ronnestad in particular, there is a level of conceptual analysis which affords the reader a deeper understanding of the phenomena described in this study.

7.2.6.2: Counsellors', psychologists' and psychotherapists' experiences in training: A review of the literature and how it relates to this study

The seminal works on emotional difficulties in novice therapists are those of Thomas Skovholt and Michael Ronnestad (1992, 1993, 1995, 2003). They contextualise these emotional difficulties within an overall model of therapist development which they initially describe as having eight phases (1992), but later condensed to six (Ronnestad & Skovholt, 2003). However, it is necessary to be cautious about attempting to draw any direct comparisons between the stages described in therapist/counsellor development and the experiences of the research participants in this study. Descriptions of the therapist/counsellor trainees suggest that the majority of these individuals are undergoing their first

about the instructions given in class and the textbooks, I barely heard the client!". This is strongly echoed in this quotation from one of the research participants from this study: "*I have hardly started treatment with anybody because I have been going through the assessment period where I'm mainly learning I've got so many things to remember about*" Ronnestad & Skovholt (1993) offer a potentially useful insight into why this might be, suggesting that this experience is partly due to novice practitioners not yet having been able to sort and hierarchically organise complex conceptual material, whilst Chi et al (1988) suggest that beginners in this situation have not yet internalised conceptual knowledge so that they can operate from tacit and intuitive knowledge, the base they suggest is used by experts. This quotation from one of the research participants in this study supports such a formulation: "*That it that's got a lot to do with it and I don't have the model fixed in my head, I really have to think about it and I get confused*".

Eells et al (2005) shed further light on this phenomenon by making the reasonable claim that unlike the fields of for example maths or computing, where with the exception of the very highest conceptual levels knowledge can be said to be *well-structured* in that it has clearly defined initial states, goal states and a systematic way of solving problems, psychotherapy instead relies on *ill-structured* knowledge where clients initial and goal states are often either unknown or changeable and there exists considerable difference of opinion even from within the profession as to how to solve a given problem. This obviously adds to the potential for confusion and feelings of being overwhelmed within the trainee who are unsure of what changes the client is hoping to make, how to achieve them and what the consequences of those changes might be.

Historically CBT has been thought of as a model of psychotherapy which is perhaps better structured and more easily defined than for example psychodynamic psychotherapy. Ronnestad & Skovholt (2003, p.12) describe the concept of the 'life-saver' for beginner therapists where they are taught " *easily mastered, straightforward, counselling/therapy methods that can be absorbed quickly and that hopefully can be applied to all clients*". This description could be taken as a shorthand for CBT and certainly my own hope for the training sessions described in this thesis was that these aforementioned characteristics of CBT would to some extent compensate for the relative brevity of the course and

allow the research participants to more quickly grasp the principles of the approach, giving them something which they could realistically use with clients/patients. As evidenced by the themes and issues of anxiety and confusion to emerge from our data, the problem of novice/trainees sufficiently internalising complex conceptual information appears to remain relevant to students of CBT students as it does to those training in other less structured forms of therapy/counselling although perhaps to a lesser extent.

Again, in the transcripts of the research participants from this study, there are many examples of difficulties experienced in preventing the patients' distress from adversely affecting their own emotional state e.g. "*one of the areas where I don't feel as confident, say where things do get very very difficult, if somebody's getting a bit upset then I could deal with that, but the lady with major anxiety problems, I had one of the most difficult sessions ever with her last week, because there was so much negativity coming up, and anything I was going to say was not going to be going in*" Skovholt & Ronnestad (2003, p.49) again offer a useful conceptualisation which allows the reader to better understand what is behind this phenomenon, framing such an experience in terms of "*Porous or rigid emotional boundaries*". This describes the ability of novice therapists to regulate their emotions as being a core developmental challenge. They go on to suggest three styles of reacting to such intense data, two being maladaptive: *Premature closure* is where the therapist/counsellor prematurely disengages from the overwhelming emotional experience of the client to the detriment of the therapeutic process. *Insufficient closure* as per the example above is effectively where he/she is unable to emotionally shut off after the session and finally *functional closure* is where the therapist/counsellor can attend to the clients distress for its duration but not get stuck in "*continuous and nonprogressive reflection*" after the session. Of the two maladaptive reactions there is considerable evidence from the research participants' experiences as described in this study that insufficient closure is a common phenomenon, in effect describing those experiences where the research participants continue to feel anxious and worry long after the session with the patient has finished.

Bischoff (1997) in a study of trainee family therapists further develops this issue of boundaries, describing how novice therapists due to the influence of overly permeable boundaries tend to make themselves inappropriately available, emotionally at least, to their clients, often at the expense of their own relationships with family and friends. Bischoff describes trainees experiencing the need to *do something for* their clients as well as inappropriately taking on responsibility for client problems and the solutions to those. Once again this serves as confirmation of the phenomenon described in the results section of this thesis, category 2, subcategory 3 for example:

"I'm just struggling a bit at the moment with the well it's collaborative, as much has to come from the client yet at the same time you're the therapist so you have to be kinda, it's that concept I'm not just quite got a grip on yet"

He goes on to label this "*The impostor syndrome*" (Bischoff 1997, p.569) where the trainee or novice, struggling with his/her confidence due to the unrealistic expectations which they have of themselves feels a lack of legitimacy in the role of therapist, again a theme which is present in the results from this study.

As with Skovholt and Ronnestad, Bischoff suggests that learning to better manage these boundaries and modifying these unhelpful beliefs concerning responsibility for change are key stages in the process of therapist development. This also mirrors exactly what this researcher was attempting to do by addressing these issues within the context of the action research component of this study.

A third finding from this research, which is both mirrored and contextualised within a deeper understanding in Skovholt & Ronnestad's work is what they refer to as "*Glamorised Expectations*" (2003, p.53). They describe novice and beginning therapists as having idealized expectations of both the personal/professional qualities of perceived experts and supervisors as well as a wildly exaggerated expectation of the ease and rapidity by which they achieve clinical results. The trainee then, mistakenly of course, assumes that his/her own goal should be to strive towards similar levels of perfection with the reasoning being that if they can be *good enough* then of course the patient/client **must** logically improve. Examining the data from this study then it becomes apparent that this phenomenon has an impact on two separate sub-categories of the

research participants' experiences. Firstly in the 'unfair comparisons with others' subcategory there is this typical example: "*and I think you do have this image of this perfect therapist that goes in and does wonderful things*" which clearly describes the same phenomenon which Skovholt and Ronnestad referred to. Secondly the existence of the idealised expert leads as Skovholt & Ronnestad point out (2003, p.52) to inevitable disillusionment as the trainee discovers that she/he cannot hope to emulate their idol. They go on to describe how the trainee in effect has two potential scapegoats at this point, either him/herself for not being good enough or some aspect of the training including the trainer. Again both aspects of this phenomenon are confirmed in the results from this study with research participants either offering the brevity of the training as a reason for not applying or instead focusing on their own perceived limitations e.g. "*I think we look at basic principals of CBT in a lot of the work that we do but it's not actually sort of promoting that sort of thing or saying to them we will work on using a CBT approach, I really don't feel I've got the skills for that to be honest*".

Ronnestad & Skovholt (2003, p.14) also describe another phenomenon that resonates with the experiences recorded in this study. They describe how " *(many students) want not only to avoid making mistakes, but to excel in their work. Many feel pressure to do things more perfectly than ever before. A consequence is that interns usually act in a conservative, cautious and excessively thorough fashion*". Examining the following quotation from one of the research participants from this study when asked why she had not yet offered a patient a written case formulation there is a perfect illustration of what Ronnestad & Skovholt describe: "*cos that's a very formal, well it's official and it's there and it's in black and white, and it's something that the patient/clients gonna see, so it has to be very very accurate and precise, very well... there has to be good knowledge behind it.*"

Whilst Skovholt & Ronnestad, Bischoff and others have carried out seminal work in identifying and categorising issues of confidence and anxiety in the context of career development in therapists, it was Elizabeth Nutt-Williams (1996, 1997, 2003) and her co-authors who offered a more cognitive-behavioural understanding of these issues, particularly with a focus on therapists' 'self-talk' and of particular relevance to this study, the beginnings of

an investigation into how therapists manage and overcome these negative, unhelpful thoughts. In an earlier article Hines et al (1995) had gathered, identified and categorised the cognitions and self-talk of sixty group therapists using the thought –listing technique developed by Brock (1967) and Greenwald (1968). Surprisingly however this study focussed heavily on thoughts relating to the actual process of therapy itself typically categorised as *observation of group member* or *internal question regarding intervention toward group process*. Very little is mentioned of the therapist's thoughts in relation to themselves and their own personal concerns and anxieties. It is hard to see this omission as anything other than an opportunity missed.

Nutt-Williams & Hill (1996) highlighted that little was known about how therapists' in-session cognitions influenced therapy process variables. They went on quite reasonably to suggest that novice therapists in particular were prone to negative thoughts about their performance in effect citing Skovholt and Ronnestad's findings. It has been a key assertion of **this** study that the anxiogenic and self-critical thoughts described by many of the research participants have in fact been *cognitive distortions* in that they may not accurately reflect the reality of the situation and are instead both inaccurate and unhelpful. Nutt Williams & Hill cite evidence from the literature to back up this assertion, namely Elliot (1985) and Hill et al (1994) who showed how therapists were generally more critical of their interventions than their patients were. What Nutt-Williams& Hill (1996) found was that negative self-focused self-talk of the kind described in the negative thinking category of this study, worry about how their client was reacting to them, worry about what to say next etc tainted the therapists perceptions of the therapeutic process. Nutt-Williams et al (1997) found further evidence of the impact of these negative thoughts by describing how novice therapists who had difficulty in managing their internal dialogue often demonstrated incongruent behaviours such as displaying annoyance or becoming overly directive. Whilst there is no evidence of these incongruent behaviours in the findings of this study, there is ample confirmation of the adverse impact which negative self-dialogue has on the therapeutic process. In the same study there is a description of how the novice therapists actually manage the problem of distracting negative self-talk. Such strategies as thought-blocking, refocusing on the patient, coaching themselves to "relax" or get

"centred" were commonplace. An interesting strategy described in Nutt-Williams et al (2003) which has also been described by research participants from this study was self-disclosure, meaning that the therapist would admit to the client that they felt overwhelmed or were struggling to make much sense of what the client was telling them, to all intents and purposes using this strategy as a safety valve to lift the pressure of expectation.

There are two important provisos regarding the validity of relating Nutt-Williams et al's work the conclusions derived from this study. Firstly her focus was largely on *in-session* negative self-talk (or self-awareness to use her own preferred terminology) and in session self-management techniques. The data from this study was gathered from *post session* reflections by the research participants and the strategies which they developed to overcome their difficulties again appeared to be devised through reflection outwith the session. It seems reasonable however to suppose that the core of what is thought about in session translates in the main into post session analysis. Secondly, Fauth & Nutt-Williams (2005) in a follow-up study discovered that the therapists' level of awareness of their own negative emotional and cognitive responses in session did not always have a negative correlation i.e. with impediment to the therapeutic process. In that study it was found that increased awareness of these issues actually *facilitated* the therapeutic process, Fauth and Nutt-Williams concluding that there might a baseline level of awareness, which is facilitative of the therapeutic process but that fluctuations above that baseline might render that awareness counter-productive and that the actual content of that self reflection, such as what was said, was also very important.

There are strong parallels between the theory generated by Nutt-Williams et al's (1996, 2003, 2005) studies and those from this study in terms of the influence of negative self-evaluation on the therapeutic process and therefore on training transfer. Nutt-Williams also examines the possibilities of how therapists might manage the impact of this negative self-talk, as does the *action* component of this study. I would however advocate, as described in the action research section of the thesis, a more pro-active approach. It is clear from both Skovholt & Ronnestad's as well as Nutt-Williams et al's work that novice therapists suffer from anxiety, that this anxiety interferes with the process of therapy and that there is a cognitive basis for that anxiety which is based on a distortion of reality

(unreasonable self expectations, the belief in the idealised 'expert' and inaccurate perceptions of negative evaluations by patients). Logically then, if one is to accept the above cognitive-behavioural conceptualisation of the problem, there must be strong grounds for believing that coaching the novice therapists to develop awareness of and then to actively challenge these negative, unhelpful thoughts (to all intents and purposes applying the CBT paradigm to themselves) might better facilitate forward motion through the process of training transfer than passive strategies such as distraction or thought-blocking which do not actually address the cognitive root of the problem. In clinical work a core component of the CBT approach when treating a psychological condition such as anxiety or post-traumatic stress disorder is to provide the patient with information about their illness which might allow them to better understand its causes, what symptoms might be expected and how it might best be managed. Similarly for healthcare professionals taking their first tentative steps in the domain of psychotherapy, it seems reasonable to assume that if they were to be made aware of, or given access to, a condensed synopsis of the key literature referred to in this section, in other words what they might be letting themselves in for, as well as of course the relevant understandings derived from this study then they might be able to reframe their experiences as part of a normal process which most beginners in their situation experience. They might then find it easier to successfully implement the cognitive challenges to their negative thinking it is hoped they might make. This, in effect, being a summary of the aims of the action research component of this study.

7.2.6.3: Section conclusions

It is worth concluding by revisiting the proviso from the beginning of this section, namely that the subjects of the literature referred to here are novice/trainee psychotherapists. The research participants in this study are not. The gulf between the two groups is graphically illustrated by one of the conditions used to define *novice therapist* offered in Eells et al (2005) namely that they should have had less than 1500 hours of supervised psychotherapy experience. Nevertheless, I believe that I have demonstrated how the experiences of the two groups do contain strong parallels and equivalences,

which allow meaningful comparisons to be drawn between the findings of this study and those of the literature reviewed in this section. The studies cited here by Skovholt & Ronnestad confirm the presence and unhelpfulness of the negative thinking styles found in the research participants from this study, and also show remarkable similarities to the specific subcategories developed here in chapter 6 Section 2 '*negative thinking*'. Both Skovholt & Ronnestad and Nutt-Williams et al begin to show the detrimental impact this has on the trainees performance and hence training transfer itself, which again is reflected in the cognitive-behavioural conceptualisation used in this study. The action research component of this study where an attempt is made to address the research participants anxieties is broadly similar in ambition can be seen as a development of the work of Nutt-Williams et al (1997) where they draw attention to strategies which the trainees can use to begin to manage their anxious thinking. This study however does much more than simply offer confirmation of findings from the existing literature. None of the studies cited above make reference to the experiences of nurses or other health care professionals training to deliver elements of psychological therapy approaches within their existing professional role. Neither do any of the above studies offer a complete cognitive-behavioural formulation of the process they are describing, linking the causes and effects of thinking styles, emotions, behaviours as has been demonstrated in this study. Finally the possibility that these problems might be alleviated by utilizing an action research approach whereby the understandings and insights gained into the trainees experiences are incorporated into the training process itself in order to pre-emptively address these anxieties and therefore improve the effectiveness of the training, has not been considered in the field of psychosocial intervention training prior to this study.

7.3: A consideration of the inclusion of the Occupational Therapist study and the Diploma CBT respondents within the main study

7.3.1: Introduction

This study is primarily an account of mental health nurses training in cognitive behavioural therapy. Three cohorts of nurses attended the workshops and were sampled as research participants to provide the raw data for the analysis phase of the study. There were however two additional discrete groups of respondents who were also included in the study. Firstly, one cohort of occupational therapists who attended the third of the series of workshops are included within this thesis in chapter 7, written up as a separate study. Secondly, interviews were conducted with four respondents from the University of Dundee Diploma in Cognitive Behavioural Psychotherapy course.

This study because of its focus on the singular, where in this instance the singular is this researcher's teaching and the impact it has on the clinical practice of those who are taught, can be though of as a case study. It also utilises an action research methodology and as a consequence, as Yin (1984, p.23) describes "*investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident*". Accordingly there can be no attempt to manipulate or artificially pre-select the research participants who make up the various cohorts. They are largely the same individuals who I would be teaching even if I were not carrying out this research. There remains however a duty on the part of this researcher to ensure the reliability and truthfulness of the study. The various methods by which I have attempted to ensure this are described fully in chapter four of this thesis. One of the methods described in that chapter is triangulation. (Hammersley and Atkinson, 1996: p.230) define this as: "*The checking of inferences drawn from one set of data sources by collecting data from others*".

Accordingly, when faced with the prospect through circumstance, of the third cohort to be taught and followed up as research participants being occupational therapists and **not** nurses, this researcher encountered a key decision regarding the direction the research design would take. Either an attempt could be made to integrate this cohort into the main study, effectively expanding its scope and

aims to provide an account of how nurses ***and*** occupational therapists experienced the task of applying CBT training in their clinical work, or somehow the occupational therapist study could be included in the thesis but with the accounts of the two professions somehow kept separate, or the decision could be taken to simply not include that cohort in the study.

The decision was eventually taken to include the occupational therapist cohort, but as a separate 'study within a study'. The rationale for this was as follows: Firstly, it was considered that the inclusion of findings from a profession other than nursing in the main body of the thesis would result in an over-generalization and potentially dilute the understanding which might be gained from a mostly nursing only study. This argument of course applies equally to the results from the occupational therapists also. The second option of not including the occupational therapist cohort in the study was quickly discounted because of its potential for to provide additional, rich and relevant data. It became evident therefore that this cohort could be used to enhance the reliability and truthfulness of the main study through its inclusion as a separate study for the purposes of triangulation. How did the experiences of the nursing and occupational therapy cohorts compare? What differences and similarities were present in their post-training experiences? How might the understandings gained from one profession inform those gained from the other?

The inclusion of the occupational therapy study was therefore one method of between subjects triangulation that was available to this researcher to use within the research design for this study. A strength and weakness of this approach however was that both groups, although from different professions, were undergoing exactly the same training. Accordingly the decision was made to approach the University of Dundee who, for some 15 years now, have run a post-graduate diploma in cognitive behavioural psychotherapy course and with whom this researcher trained in 1995 and retained some professional links with. The course directors were kind enough to allow me access to their students for the purpose of interviewing them about their experiences of attempting to implement CBT with patients/clients (the course required that each student attempt supervised CBT with a minimum of eight patients as a core part of the training).

This would afford the study an additional source of triangulation, still students undergoing CBT training, but this time from a far lengthier, more formal, award-bearing course with different trainers and training environments. A total of four interviews were conducted with Diploma CBT students and these are described in more detail in section 8.3 of this chapter.

This chapter therefore will examine the findings from both the occupational therapist study and the diploma CBT students, summarise their conclusions and discuss how they inform the findings from the main (nursing) part of the study.

7.3.2: The Occupational Therapist study

The findings discussed in this section refer to the cohort of occupational therapists written up as a discrete study in chapter 6 of this thesis.

Although the experiences of the occupational therapists are presented here in isolation from those of the nurses included in the main study, it is important to point out that it was considered to be impractical to treat the grounded theory analysis of the data from the occupational therapists as being entirely uninfluenced by the existing analysis for the nurses. At the time the occupational therapy study was conducted, two cohorts of nurses had already been analyzed and 'written up' for the transfer report between MPhil and PhD. Preliminary theorizing had begun, categories had been developed and in general this researcher was beginning to develop insight and understanding into how research participants experienced the task of applying the CBT training in the real-world environments of their clinical areas. Although the impracticality of beginning any grounded theory study with a genuine 'tabula rasa' is fully discussed in the design chapter of this study, it is considered necessary here to bracket the extant knowledge which this researcher was bringing into this analysis.

Comparison of the analysis and category development between the nursing and the occupational therapy cohorts reveal striking similarities in terms of experience, processes and context. Both groups experienced difficulties in applying a 'pure' CBT approach to their clinical work. The negative thinking category described in the analysis of the nurse's experiences was also evidenced in the experiences of the occupational therapists. Both groups displayed

anxieties related to fears that their inexpert attempts to address their patients problems might either make things worse or bring to the surface emotionally difficult issues, which they would then be unable to resolve. Both groups typically placed unreasonable and unhelpful amounts of pressure on themselves, expecting that they should be able to perform up to in idealized standard with both groups significantly describing concerns that they would fail to be able to perform to the levels of competency which they believed was expected of them by patients, relatives and colleagues.

There was also significant correspondence between the two groups in the key area of identity, although because of different historical and political influences on the two professions professional and role concepts there was variation of the specific reasons for the dissonance: Nursing as has already been described in the main literature review to this thesis, is only recently beginning to emerge from the shadow of medical domination both in terms of domination by medics themselves and the domination of the medical model of care. Accordingly much of the role dissonance as described by the nursing cohorts had its origins in their socialization into this medical model where clinical or therapeutic responsibility was traditionally the domain of doctors or psychologists with the nurses either adopting a custodial role or at best acting as the medic's eyes and ears. The prospect of adopting a CBT approach brought with it a requirement to take joint therapeutic responsibility with the patient, to provide, describe and justify treatment options and potentially, to offer written case formulations to the patient. This, particularly in the case of those nurses who had worked for large parts of their professional lives in a ward environment, led to role dissonance. A similar phenomenon was also detected among the occupational therapists. The role dissonance for the occupational therapists appeared also to be a product of previous socialization into a role identity. Several of them described an underlying ethos within the profession for which the shorthand "*do for*" or "*fix it for*" was frequently used. In essence this meant that the occupational therapists habitually found themselves solving their patients/clients problems for them. Accordingly the success or failure of their interventions very much became their own responsibility. This seemed at least partly to be influenced by pressure of work in that it was often believed that this was the quickest and most efficient way to achieve turnover of patients. The philosophy of therapist/patient

relationship as taught in the CBT model was one of collaborative empiricism where each partly share responsibility for information gathering, generating treatment options and ultimately for change itself. Although most of the occupational therapists could relate to this approach *in principle*, it nevertheless caused them to experience some anxiety concerning the legitimacy of relinquishing some responsibility to their clients as well as expressing concerns regarding how the increased amount of time a collaborative approach would be viewed by their managers even though they recognized that it would be more likely to create lasting improvement in the longer term. The majority of the occupational therapist cohort actually worked in non mental-health areas, but had attended the workshops because they recognized a psychological dimension to their clients problems, a need which they believed was being unmet. This however brought with it an additional source of dissonance and hence anxiety. Many of these occupational therapists believed that it was expected of them to provide pragmatic, physical solutions to their client's problems. They felt uneasy and vulnerable to questioning from various sources when faced with the prospect of at least partly beginning to address psychological issues with their clients.

In the nursing cohorts, a process is identified whereby the nurses employ innate strategies in order to reduce the aforementioned role dissonance and therefore progress the incorporation of the CBT training in their clinical work. A similar phenomenon was detected with the occupational therapists. They typically employed similar strategies to their nursing colleagues. This included making CBT more manageable by not explicitly referring to the approach they were taking as being "CBT". They would also minimise the risk of a hostile reaction by patients by waiting until the patient had made some reference to the psychological component of their problems rather than pre-empting the issue themselves. In common with the nurses they would avoid the use of jargon and there was also evidence that like the nurses some of the occupational therapists were also engaged in a process of positive self-talk in trying to challenge their unhelpful negative thinking. Practical strategies were also very much in evidence in the two groups, allowing extra time for planning or rehearsing opening gambits were evidenced in each group.

The process of critical reflection on the norms of professional practice, triggered by the impact of attending the workshops and the challenge of applying the training was also evident in both the nursing and the occupational therapy groups.

Both groups were forced to consider the often unspoken boundaries which had typically defined their professional practice and identity. Both groups also expressed the opinion that in theory at least, CBT fitted well with how they believed they should be practicing as experienced professionals, in both cases with CBT potentially providing them with the tools to meet unmet needs in their patients/clients. There was also however evidence of unresolved role dissonance in both groupings. Some nurses found the move away from the medical model to be uncomfortable and similarly some occupational therapists struggled to move away from their more pragmatic, 'here and now' focus and embrace some of the more conceptual aspects of the CBT model such as origins of core schema or activating events.

Overall the experiences and processes identified in the two groups proved remarkably similar. There is greater depth and expansion of the categories in the main nursing analysis but that is clearly a product of having a far greater number and variety of research participants to interview to allow for genuine saturation in the analysis.

One possible reason for this similarity emerges when the two literature reviews for each study are compared. In the case of both the nurses and the occupational therapists, when their historical and current political contexts are considered, the picture which emerges is of two professions each for different reasons in the midst of an identity crisis brought about by the increasingly rapid social and political changes we see impacting on the health service today in the United Kingdom. As was described in chapter 2 of this thesis, the expansion of the nursing role, away from the influence of the psychiatrists and their domain of the psychiatric institution has caused the profession as a whole, as evidenced through the nursing press (Chapter 2), to urgently ask and address the question "How do we define ourselves as nurses and what we do as nursing, what, if anything, makes us unique?" Occupational therapists also now find themselves increasingly in community-based settings and coming into role-conflict with other professions. Their own literature is also asking some difficult and so far

unresolved questions regarding role-boundaries, the most relevant one to this particular case being: whether or not as a profession they should integrate generic, non-occupational; therapy specific interventions such as CBT into their routine practice (Meeson, 1998; Lloyd et al, 2004).

It is reasonable therefore to suggest that the role-dissonance and consequent anxiety which appears to have a such negative influence on training transfer, is very much a product of this underlying confusion, uncertainty and insecurity of identity which is exerting such an apparently malign influence on both professions.

7.3.3: The Diploma CBT respondents

These additional interviews were carried out in an attempt to add depth to the study by employing elements of what Shultz & Kerr (1986) described as the 'most-different-systems' approach, where variation is actively sought through the availability of relevant comparative data. Whilst these additional interviews could be seen as an attempt at triangulation, they are certainly not intended to achieve convergent validity of a single concept, rather as Fielding and Fielding (1986) suggested, using a combination of sources to achieve greater *completeness* by portraying the contextual elements of the phenomenon of interest (Jick, 1983).

The four volunteers kind enough to consent to be interviewed consisted of four students who at the time of the interview were in their second term of the one year full-time or two years part-time course. These included one forensic psychiatrist, one community psychiatric nurse, one clinical psychologist and one occupational therapist.

The sampling of these respondents was pragmatic and random in that they were the ones who volunteered. Interviews were semi-structured and formatted to allow this researcher to follow-up leads and areas of interest generated by the previous analysis and results (Polit & Hungler, 1987).

The data for these respondents was collected and analysed exactly as it had been for both the nurses in the main study and the occupational therapy study. Rather than beginning the grounded theory analysis from scratch the same procedure was carried out as had been applied to the occupational therapy study. Open

coding was first performed on the interview transcripts and these were then compared to the categories developed for the nursing cohorts #1 and #2 to allow for the identification of cases which would either fit with the existing data or prove to be a negative case. For these respondents, unlike those from the occupational therapy study, the research data collected through interview and the subsequent grounded theory analysis was integrated into the main results section of this study.

Rejection of the use of triangulation on ontological grounds in qualitative strategies of inquiry is common (Silverman, 1993) due to its origins as a positivist means of verifying the reality of a given situation. Kelle (2001) however echoes Handy (1997) by suggesting instead that triangulation in interpretivist studies such as this can be used to increase the wholeness of understanding of the phenomenon under study and add breadth and depth to the analysis.

Whilst the inclusion of the Diploma CBT respondents as an example of between subjects triangulation was very much intended to be for the purposes of completeness rather than verification, in keeping with the ontological position adopted throughout this study, it was nevertheless quite striking just how many similar themes actually **did** emerge in their accounts of their experiences in trying to apply CBT when compared to the research participants in the main body of the study despite the numerous situational differences between the two groups and the training being given.

Unhelpful, negative thinking in particular was strongly evidenced. A typical example is represented by the following quotation from one of the Diploma CBT respondents "*if I go on to work with the more acute patients that you're sort of representing CBT so this would be their one shot at it so you would want to get it right*". This fits perfectly as an example of the 'putting pressure on self' sub-category of category 2 (negative thinking). Concerns over how they were being perceived by the patient were also again in evidence in sub-category 5 "*Daunting, quite anxiety provoking because I have all my own fantasies of 'well how am I being perceived by the patient, what are their expectations and fantasies of me?*"

A substantial number of additional examples of strategies used to overcome internal barriers to applying the training also emerged, adding greatly to the depth and variety in this category. Category 2, sub-category 3 "*I suppose you feel that when you go into a session it is a failure, you feel terrible, you go 'Oh my God!' but then you think to yourself 'obviously you're just learning at the moment' and that's what this is, a learning experience*" which corresponds perfectly with category 2, sub-category 3 'challenging own thinking' or "*I think I'm probably a bit more upfront now about what CBT actually is. I put that to them in the first session whereas at the beginning maybe it would have been the second session I would have tentatively explained the model to them*" which is another example of the pragmatic strategies (sub-category 4) also devised by the research participants to help overcome these barriers to progressing their training.

Another category, which the data from the diploma CBT respondents added depth too as well as validating its inclusion as a distinct category, was that of category 4: Identity and relevance issues. Diploma CBT respondents, like their counterparts in the main study had identified an unmet need in their routine clinical practice which they felt that CBT could help them meet: " *We didn't delve very much into the psychological aspect of it and that's where I was getting frustrated*". Also there was frequent mention of a positive fit with how the respondents felt they should be working with patients: "*It's actually been brilliant...to sit in the room with the person and actually speak to them and actually listen to what they are saying and for them to have experience of me listening to what they are saying and responding has been great*".

The core category of the threshold to be crossed, *on the verge*, is represented in such statements as: "*I think it's just taking that jump into it*" although probably because the students here, unlike the research participants in the main body of the study, did not have the choice to apply or not to apply the CBT training if they wanted to meet the course requirements, then it is less in evidence as they had in effect been propelled over the threshold by the demands of the course.

One rather striking 'negative case' however also emerged from the Diploma CBT respondent's accounts of their experiences. One of the respondents was a psychiatrist, and the only medic to be included anywhere in this study. Any reader of this thesis will by now be well aware of the almost universal evidence

of unhelpful, 'negative' thinking concerning typically, their own abilities or the magnitude of the CBT task amongst the respondents accounts of their experiences. The data gathered from the psychiatrist was notable by virtue of the complete **absence** of evidence of any such self-doubt, anxiety or dissonance. Although she was, like her nursing and occupational therapy colleagues, profoundly aware of the CBT approach necessitating a different mode of clinical approach, her reaction to this was entirely positive. Like many of the other respondents included in this study the change of approach triggered reflection on the norms and limitations of previous practice as described in the '*reflecting on boundaries'* sub-category of category 4. In this instance however, having the time and space to listen to and work collaboratively with patients and their problems rather than a five-minute consultation to review medication, was felt to be: "*really a privilege because my time with patients is so closely monitored and so short that it's nice to have a decent amount of time to spend with patients, so I really like that part of it*".

Other noteworthy quotes included:

- *"Quite easy because I'm naturally inclined to work this way"*
- *"It's not a problem with me selling it to people"*
- *"I don't have any trouble explaining it"*

and perhaps most tellingly of all, when replying to the standard question; "Do you ever look at yourself and think, 'am I selling the benefits of this (CBT) clearly enough?'" her reply was unapologetically

- "*No, it seems much more on their part*".

Whilst it would obviously be wholly inappropriate and contrary to the epistemological position adopted within this study to attempt to make sweeping generalisations about the relative personality characteristics and psychological dispositions of say, nurses and medics from this one brief interview, much as it would be from the data collected from the clinical psychologist also considered here, it is nevertheless an interesting contrast in attitude. The confidence and ease with which the respondent adapts to the CBT approach may well be a product of that individual's history or personality traits instead of a characteristic of psychiatrists in general. It is worth considering however that unlike nursing and occupational therapy, there is little in the literature to suggest that psychiatry is a profession currently in the grip of an identity crisis. Since

much of the negative thinking described in the nurses and occupational therapists was a product of role dissonance I believe it is reasonable to infer that the relative security of psychiatry as a profession may well account, at least partly for the ease in which the role transition, on this one occasion was managed. A comparative study between psychiatrists and nurses for example, would clearly be an interesting avenue to explore in any follow-up study.

7.3.4: Chapter conclusions

As has been emphasised throughout this thesis, the aim of this study has not at any stage been verification or generalisation. Instead, this researcher has attempted to provide a rich, in-depth account of the one particular phenomenon under study here. Shih (1998) suggests that triangulation can serve two legitimate purposes in research, the first being verification and the second completeness. It is primarily for this later purpose therefore that the triangulation strategies described in this chapter have been employed in this study.

Numerous examples have been provided in the preceding two sections of this chapter which illustrate how the experiences of both the occupational therapists and the diploma CBT students have enhanced the quality of understanding portrayed in the categories and sub-categories of the results chapter of this thesis. It has also been impossible however to ignore the striking similarities between the experiences of the main group of nursing research participants and the two other groups described in this chapter. There was strong evidence for internal barriers to training transfer in the form of unhelpful or negative thinking, many of the triangulation respondents also showed evidence of the use of strategies to overcome these barriers and in all groups the research participants/respondents found themselves reflecting critically on the norms of their professional practice and how training in CBT might be useful in addressing some of the deficiencies identified in that critical reflection. I would assert therefore that the use of triangulation as described above has not only enhanced the richness and depth of this study but has also enhanced this researchers claim to the truthfulness of the understanding and theory developed through this research process.

Chapter 8: Conclusions of the Study

8.1: Introduction to the chapter

This chapter takes the main literature review, the results and the findings described in the previous chapters of this study and presents the conclusions which this thesis arrives at. Along with a summary of the main conclusions of the research, this chapter will also consider what new knowledge can legitimately be claimed for this study in terms of its contribution to the literature. Given also that one of the goals of this study was to allow this researcher to improve the effectives of his own teaching through an action research cycle, it is also necessary to review the culmination of that process thus far. Research generates more research and new knowledge suggests new avenues for exploration. Accordingly, it is also necessary in this chapter to consider what further research might reasonably be expected to follow-on from this study, both from a personal perspective and for the wider research community. Finally, this study has also been a unique personal journey for this researcher and a parallel process of growth and development has taken place for me as a researcher along with the growth and development of the theory which has emerged from the research process. I have therefore included a brief personal reflections section at the end of this chapter.

8.2: Contribution to the literature

In the introduction and initial literature reviews for this thesis, three main areas where the existing literature is held to be under-researched are described. These are:

1). Understanding and exploration of the link and relationship between continuing professional development interventions and either change in nurses' practice or improvements in patient care (Warmuth, 1987; Ferguson, 1994; Jordan, 1998, 2000). A lot of money and time is devoted to this now statutory requirement but little is understood about what impact such continuing

professional development has or why. This is particularly true for mental health nursing.

2). Internal or identity-related barriers to training transfer. There is a reasonable body of research which highlights the environmental barriers and obstacles which can hinder or prevent training transfer in the healthcare field e.g. Tzinier et al (1991).

Whilst some studies have hinted at the possible mediating role of internal barriers (Mackay et al, 2001) or acknowledged that the internal dialogue of trainee therapists might play a part in the therapeutic process (Nutt-Williams, 2003), there is no real attempt in the literature to identify, describe or conceptualize these internal, cognitive and affective barriers to training transfer, nor is there any real suggestion of what interventions might be employed to facilitate their resolution.

3). It is highlighted in the main literature review for this thesis that nurses are undergoing a historical and rapid expansion in role. Once again however, what literature there is on this issue tends to be either political commentary or focuses on pseudo-medical issues such as nurse prescribing. The expansion in nurses undertaking training in psychological/psychosocial therapies is documented in the introduction to this thesis. There has unfortunately not however been a parallel expansion of the literature describing and attempting to understand this phenomenon.

It is this researchers assertion that the results presented in this thesis have made a significant contribution to the literature in four distinct but related aspects of the gaps in the literature highlighted above:

1). The role of cognitive distortions and their basis in role identity:

The results from this study have, for the first time, revealed a cognitive basis for the anxieties already described in the literature, experienced by healthcare professionals training in psychological therapies. There is strong evidence for the presence of cognitive distortions in the participants, essentially underestimating or undervaluing their own abilities whilst simultaneously overestimating the demands of the task in hand such as applying the training to clinical practice. The research participants often display insight into the

unreasonableness and unhelpfulness of these thoughts and therefore acknowledge them as distortions.

The research also suggests that at a higher conceptual level, these thoughts can be a consequence of dissonance in the participants' sense of core professional identity. Whether nurses or occupational therapists, the research participants have been socialised over the years into a role with certain values, expectations and norms attached. These apply equally to the participants as well as to those with whom they interact in their professional role, colleagues, patients and relatives all of whom have their own expectations of the nurse/occupational therapist. Where the CBT training demands such an extension of role the participants no longer believe it to be within their core identity. They find themselves, as evidenced by many of the quotations from the participants, trying to adopt a role which they believe is really the domain of other professions such as psychologists or clinical nurse specialists. This leads to dissonance, causes the participant to question the legitimacy of what he or she is attempting and triggers the kind of cognitive distortions described above.

2). The identification of strategies used by research participants to overcome internal barriers to training transfer:

This study has identified several classes of implicit strategies which the research participants have employed to successfully shrink the aforementioned dissonance and consequently lessen their anxieties. There are numerous examples from the interview transcripts of participants challenging their own unhelpful thinking styles, making the CBT approach more manageable by for example not naming what they do as "CBT" and lowering their expectations of themselves. There are really no equivalent findings in the existing literature which identify or describe a similar phenomenon under these circumstances. I would therefore assert that this represents a highly significant contribution to the literature not only because it represents genuinely new knowledge but also because it forms the basis for the main potential practical and pragmatic benefit to emerge from this study which is described in part four of this section below.

3). The conceptualisation of the research participants experiences using a cognitive-behavioural framework:

In chapter six of this study, two diagrams are presented which conceptualise the difficulties described above in a cognitive –behavioural framework. It is this researchers opinion that this represents an important contribution to the literature in its own right. As has been discussed earlier in this thesis, the existing literature has so far provided only a shallow, incomplete and fractured account of the mediating role which trainee therapists' internal, emotional and cognitive responses play in the transfer of training. The presentation of a coherent model which links key historical and developmental influences on the participant's sense of professional identity with core role-orientated schemata and then describes the emotional and behavioural consequences of cognitive responses in other words distorted thinking, is a useful and original attempt to coalesce, rationalise and refine these disparate threads. The conceptualisation has particular utility in that it is presented in two forms, one to represent the participants' difficulties but also crucially one to represent how these difficulties might be overcome.

4). Expansion and novel application of the 'relapse prevention' concept:

The development of a cognitive behavioural representation of how internal barriers to training transfer might be overcome, leads to exciting possibilities. An account of how Milne (2002) developed the earlier work of Marx (1986) to utilize a relapse prevention module to facilitate training transfer is provided in chapter six of this thesis. It is this researchers contention that those strategies, which this research has identified as being employed by many of the participants to overcome internal barriers to training transfer can be distilled and integrated into future training to create in effect an enhanced relapse prevention module, which unlike Milne's does not concern itself solely with environmental obstacles, and might reasonably be expected to be more effective given that it would be based directly on the experiences of previous groups of nurses faced with the same situation rather than an adaptation of general principles from the field of management training.

8.3: Ideas for Future Research

8.3.1: Introduction

In considering what research might plausibly follow-on from this study, which direction the results and conclusions to emerge here might suggest as fruitful areas for other researchers, or indeed this one, to pursue, it is first necessary to define and describe the kind of knowledge which has been generated by this research process, what results we have from the study and what significance can be attached to them.

Grounded theory, one of the two main methodologies used here is, as the name suggests, primarily a technique for building theory which is grounded in the research data. It is not a process which allows for the verification or testing of theory and it is more than simply a means to *describe* empirical phenomena. The systematic and thorough comparative analysis at the heart of grounded theory allows for the generation of either formal or substantive theory which Glaser & Strauss (1967, p.3) contend should: "*enable prediction and explanation of behavior*" as well as being: "*useful in practical applications--prediction and explanation should be able to give the practitioner understanding and some control of situations*". The theory generated through this study is clearly a substantive one in that it is situation specific. Distilling the findings from this research down to their most concise form, the results of this study provide us with insight and understanding into how nurses training in CBT experience the task of applying that training to their routine clinical work. Internal, cognitive mediating factors with origins in the research participants' sense of professional identity, which can potentially act as a barrier to training transfer are identified. The theory developed also shows how some participants can devise and utilize innate, mainly cognitive, strategies to overcome these barriers. If this theory is accurate then it legitimately allows for the prediction that if future learners under similar circumstances, on similar training courses are made aware of the potential existence of these barriers and the detrimental effect which they can have on training transfer, and are then actively encouraged to practice similar cognitive strategies to those described in this study, then a relapse prevention or inoculation effect similar to those described

in Marx (1986) and Milne (2002) might reasonably be expected and the transfer of training facilitated.

It is acknowledged in the '*limitations*' section of this chapter that although the findings claimed for this study were valid and trustworthy within the evaluation criteria appropriate for a small-scale field study employing a naturalistic/constructivist methodology, there is always doubt as to the extent to which the findings of such a study can be generalized to other training situations.

I would suggest therefore two logical rationales for future research, influenced by the findings from this study. Either to develop and refine the theory further, or to begin to test and verify these findings by exploring their relevance and fit to other situations.

8.3.2: Developing and refining the theory

The reason why the development and refining of the theory emerging from this study ceased was that it was considered that saturation had been reached. Repeated sampling of the research participants and returns to the data were no longer generating any new understanding. This is not however the same as saying that all that can be known about the phenomenon under study is known. Rather, saturation implies that the stage has been reached where all that can be known about a phenomenon **given the limitations of data available from the defined population of informants** is known.

Logically therefore, if the goal is to now refine and develop the theory and understanding which has emerged from the study further then new populations and new data must be accessed. Given that developing and refining the theory is not the same as testing the theory, such an endeavour can legitimately be considered a *continuation* of the existing research process. Accordingly, further grounded theory study might be conducted on different populations as illustrated in the list below:

- Patients of CBT trainees: are their demands and critiques of the trainees an exaggeration or is there some basis for their anxieties?

- Managers of CBT trainees: how do they view the extended role?
- Healthcare professionals training in other psychotherapeutic modalities such as counselling: is the phenomenon limited to CBT?
- Healthcare professionals other than nurses and occupational therapists training in CBT: is the phenomenon unique to these two professions?
- Nurses and occupational therapists from other sites and locations: are these results a product of conditions specific to this healthcare trust?

Once again, it is important to stress that for this category of future research, the goal is not to have theory confirmed. The expectation would be that opening up the study to a far wider perspective would cause the initial theory and understanding to expand and develop potentially quite markedly.

8.3.3: Testing/verification of the theory

The result of this research has been the development of a substantive theory, which explains the research participants' experiences in trying to apply a newly learned CBT approach to their clinical work. Theory can be defined as "*a set of interrelated constructs, definitions, and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining or predicting phenomena*" (Kerlinger, 1973, p.9). A hypothesis is related to theory and is a statement about the expected relationships between two or more concepts that can be tested, indicating what is expected to be observed and representing a researchers best hunch as to what may exist or be found, based on the principles of the theory. Verification of the theory therefore requires that one or more hypotheses be generated which might then be tested deductively. The most obvious would perhaps relate to the modified relapse prevention module, suggested earlier as a means of assisting future trainees to develop awareness of and ultimately overcome internal barriers to implementing the training. The hypothesis would be simply that the inclusion of such a module to a training intervention would facilitate transfer. A basic experimental design where a standardized population of trainees were split in an experimental group (with the relapse prevention module) group and a control group (without

the relapse prevention module) would theoretically demonstrate the efficacy of the module, or if not, then the null hypothesis would in itself be useful. Any effect could be recorded though observation or self-report of changes in behaviour.

Another hypothesis that suggests itself from the theory is that the greater the dissonance between a trainees existing sense of core professional identity and that required to incorporate a CBT role into their clinical practice then the greater the difficulty that trainee might experience in the task. As described in previous chapters of this thesis role identity is very much a social construct. Healthcare processionals are socialized into a role through their training, the literature they access, their interactions with colleagues and so on. A reasonable hypothesis might be therefore that if a nurse has been socialized into a relatively restricted, clearly circumscribed sense of role identity, perhaps training in an environment where the medical model dominates or working largely in an old-fashioned institutional setting, then the dissonance generated by attempting to actively treat patients, offering clinical opinions, working independently of medical staff, providing written formulations and delving to an extent into the patients past, may act as a barrier to training transfer. Once again an experimental design could be devised to allow comparison between this group and another who perhaps have had a more enlightened experience of nursing, training in a more psychologically orientated environment or working in one of the increasing number of nurse-led clinics. The hypothesis would state that in comparison, this group should display less dissonance and therefore find it easier to apply the training provided environmental variables etc were standardized.

8.3.4: Section conclusions

In considering ideas for future research I am forced to consider which, if any of these options might be open to myself to conduct, and which by virtue of issues of scale and resources, would have to be left to others. In general, the ongoing, naturalistic, refinement and development of the theory would appear to be the most manageable under my current circumstances. I continue to have a teaching remit within my mostly clinical role and I intend to continue the

teacher/researcher, action research paradigm used within this study beyond its conclusion and into my routine practice. An action research process can be considered open-ended (Waterman et al, 2001), and accordingly this would allow me to gradually refine and develop theory over time, although with the proviso that any findings would in the main have only limited relevance outside my own and my trainee's situations. I would assert however that that this does not diminish the importance of the work.

The prospect of testing/verification of the theory, whilst enormously appealing and exciting, would require far more resources than myself as a lone researcher could ever muster. It would require a full-time commitment with the support of a wider research team, as well as cooperation between academia and the relevant healthcare organizations. Such an enterprise will therefore have to be left to others.

I am of the opinion however, that because of the limited population under study along with the relative paucity of related research on the understandings to emerge from this study, experimental testing or verification may well be premature and further refining/development of the theory before committing significant resources to such an endeavour would be prudent.

8.4: Implications for future training

As has been described elsewhere in this thesis, this study has incorporated an action research component as one of its two main methodologies. The aim of the action research component was to give the study *real-world relevance*, specifically to improve the efficacy of the CBT training, which I regularly provide. It has already been suggested that the grounded theory analysis of the data can be viewed as a particularly formal and methodologically rigorous means to conduct the reflection phase of the action research cycle. Accordingly one of the main goals of the study has been to utilize the theory and understanding generated to improve my own teaching in terms of making it more easily to translate into actual changes in clinical practice.

It has already been established that one of the main findings from this study has been the presence and inhibiting influence of role dissonance and unhelpful negative cognitions on the transfer of training. The main changes therefore

which the planning and action stages of the action research cycle must incorporate would be the inclusion of direct reference to how previous trainees had experienced this phenomenon, effectively giving the trainees advanced warning of the possibility that they might be similarly affected. Another main finding of the study was insight into the implicit strategies which some participants managed to devise to successfully shrink that dissonance and challenge those unhelpful thoughts thus progressing the application of their training. Consequently, a further modification to the teaching as part of the action research cycle would go beyond simply raising the trainees awareness of the potentially detrimental influence of the negative cognitions and instead actively encouraging and coaching them to begin to utilize those strategies for themselves. It is anticipated that this should prove to be a fairly comfortable change to accommodate within a teaching program, given that the trainees will in effect be being asked to perform CBT techniques on themselves whilst training in CBT, a development of the more passive approach advocated by Nutt-Williams et al (2003) and a variation on the relapse prevention approach described by Milne (2003).

Although an example of these modifications is provided in chapter 5 of this thesis, reflecting the changes implemented for cohort #3 on the basis of the results and cumulative analysis from cohorts #1 and #2, I am of the opinion that it is only perhaps now, with the benefit of the results and analysis from the whole study that a more considered and effective relapse prevention module might be devised and incorporated into future training interventions.

8.5: Limitations of the study

There is a plausible argument that the apparent limitations of this study also account for its greatest strengths. As described in the Design and Methods chapters of this thesis, this study is a single case field study utilising a naturalistic/constructivist methodology within a teacher as researcher paradigm. The limitations of the study therefore largely concern its restricted scope. There is only one researcher and the population under study are limited to healthcare professionals, from the same employer, all living and working within a small geographical area and attending the same training course. The training itself was

also relatively brief consisting of only six half-day sessions and, as previously described, it was informal, non-award bearing and occurred out with the usual managerial/organisation training structures. It might be argued therefore that the theory which emerged through this study has limited generalisability or external validity to other training situations. The teacher as researcher paradigm although a staple of action research, also leaves the study open to accusations of researcher bias given that the researcher almost by definition is bound up with and has a stake in the outcome of the research and therefore cannot lay claim to neutral objectivity.

It is outwith the limits of this section to offer a full rebuttal of these criticisms of the methodologies used within this study, which are considered in some detail in the '*Research Design*' chapter of this thesis. It is worth however, briefly restating the quite reasonable assertion that such criticisms originate from an inappropriate starting point (Sheldon, 1998), and are employing the criteria for validity from positivist enquiry to judge something entirely different. These criticisms in effect complain that studies such as this lack transferability, the power to predict, generalise or establish universal laws. Qualitative studies such as this however should be judged according to how well they describe the particular phenomena under study (Polit & Hungler, 1999), how helpful the theories are (Lincoln & Guba, 1985) and how much 'fit' and 'grab' they have (Glaser & Strauss, 1967). Accordingly then this study must be judged within the criteria of its own methodology where issues of truth value and credibility take prominence (Field & Morse, 1985; Hinds et al, 1990) and any limitations acknowledged accordingly. In other words it is only legitimate to offer criticism of this study for the degree of truthfulness and credibility it has relating to the particular population under study and not for its lack of generalisability to any wider population.

Triangulation has already been offered as a means by which this study has attempted to ensure its validity. The triangulation used was however limited to data source triangulation, using the occupational therapists and Diploma CBT students as points of comparison. I believe that the truthfulness and credibility of this study would have been enhanced still further if additional triangulation strategies had been practical. Possible additional triangulation strategies included:

- Investigator triangulation: using one or two additional researchers would have provided potentially useful different perspectives particularly during the grounded theory analysis of the raw data.
- Data triangulation 1: Due to the time frame of the study and the pressure to begin each new cohort it was also not possible to check congruence across points in time utilising time-data triangulation. This might have generated significant new information about the participant's progress.
- Data triangulation 2: If this researcher had been aware of a colleague from perhaps another healthcare trust engaged in a similar teaching program, then participants from a different site may have demonstrated interesting differences in their experiences.
- Data triangulation 3: The decision to limit the workshops which formed the basis of this study to six, half-day sessions was very much a pragmatic one. It was basically the maximum time the participant's managers would allow them away from their clinical duties. Not having research data therefore from participants who were undergoing lengthier, more in-depth training is from a personal perspective my greatest regret from this study, The interviews from the Diploma in CBT students went some way to compensate for this but their experiences can only be considered to have partial relevance to this study due to the fact that they were largely training with the goal of becoming therapists, and not faced with the task of integrating the training into their existing clinical practice as were the participants in this study.
- Between methods triangulation: conducting a parallel study using a discourse analysis or ethnographic methodology might have added counterbalance to any weaknesses inherent in each methodology alone as well as enriching the study as a whole.

Overall, I believe this study demonstrates the necessary conditions of truthfulness and credibility required of a good qualitative study. I contend that this allows me to assert that it fulfils the research aims stated at the beginning of this thesis namely to develop understanding of the experiences of the research participants **from this particular study.** It is for other researchers to establish how applicable these findings are to different populations. There is always room for improvement however and I believe that had I, as the sole researcher for this study, had access to greater resources particularly in terms of some form of research team, then the truthfulness and credibility of the study could have been enhanced still further by use of the aforementioned methods of additional triangulation which would have allowed for greater compensation for researcher bias and allowed for an extended period of data collection/analysis before saturation was reached so adding greater richness and depth to the study.

It is also necessary at this point to draw attention once again to the fact that this study has been conducted by a novice researcher. Although I have had access to good quality supervision throughout the conduct of this study, I would still suggest that my novice status must be acknowledged as a potential limitation of the study. Again having access to a wider research team might have ameliorated this situation.

8.6: Personal Reflections on the Study

In reflecting on what conducting this research has meant to me, turning instead from the research participant's experiences to my own, two main themes emerge:

1: My own journey as a researcher.

Prior to my beginning this research degree program my highest level of academic qualification was that of honors degree. I did not have, as many PhD students do, a previous MPhil or Master's degree in research and therefore this was my first experience of studying for a research degree. I had also never previously conducted any kind of formal research with the exception of various, fairly limited, literature reviews.

Accordingly there have been three separate processes going on in parallel throughout the duration of this study. Firstly there has been the research and the conduct of the study itself. Secondly because of my novice status, I have been engaged in learning how to 'do' the research as I was doing it. Thirdly I have been attempting to meet the criteria for the award of a Doctorate through the completion of this academic thesis.

It has been a steep learning curve and even now as I write the conclusions to this thesis it would be ridiculously naive to claim that I have now reached the summit of that curve.

The choice of a qualitative methodology has also added to the degree of difficulty which the combined tasks have presented. My previous background was in the biological sciences and then latterly in the behaviorist tradition of psychotherapy, two fields which utilize almost entirely positivist, quantitative methodologies in their research literature. Whilst the choice of a grounded theory approach gave at least the *initial* illusion of some welcome structure, the conduct of an inductive, naturalistic has proved particularly anxiety provoking, particularly in the early stages where having a clearly defined hypothesis, an experimental design or some notion of statistical probability or measurement would have proved immensely reassuring.

It had been difficult to gain any real sense of my progress or development as a researcher over the five years I have been occupied with this study until perhaps just recently. The only real pattern which I could discern was that the degree of uncertainty, dread and panic which I experienced seemed to improve slightly during the actual teaching and interview phases of the research and then worsen when I was left alone to make some sense of the research data. Recently however, whilst engaged in this 'writing up' phase of the research, I have been forced to return to most of my earlier writings and read and re-read countless academic (qualitative) research papers. I now find to my surprise that not only ***can*** I now critique these, but that I instinctively ***do*** whenever I read them. This also applies to my own work. Prior to the submission of this finished thesis the most substantial piece of complete work I had produced was my MPhil/PhD transfer report, which I submitted in September 2004. At the time I believed this to be a comprehensive, well-written and academically thorough paper. Re-reading it two years later I was amazed at its shortcomings, its naivety and lack

of depth. Hopefully this is less an indication of any inherent shortcomings I might possess and more an indication of my growth and development as a researcher. My hope is that this thesis does not represent the end of a journey but rather a beginning and that my career as a researcher will continue beyond its conclusion. I am now fully prepared however to re-read this thesis in a few years time with the same sense of mild embarrassment that I recently experienced whilst reading that transfer report again!

2: The local political context.

As the reader will by now be aware, two of the central themes of this study are how nurses define themselves and are defined by their sense of professional role identity and also how nurses experience the challenge of trying to expand that identity, in this case to accommodate a CBT component to their role. When I began this research I was a clinical nurse specialist working within a multidisciplinary psychotherapy team carrying out CBT interventions with a mixed caseload. Within a year of beginning this study our team was dramatically rescinded. For a period of time I feared redundancy and was relieved when I was eventually given a role within a community mental health team, but now with a generic component written into my job description. Although the official reason for this was given as financial, various leaked conversations suggested ulterior motives. It became clear that some individuals in the higher echelons of the service believed that 'nurses should be nurses' and that those nurses, such as myself, operating within the psychotherapy team were no longer working within what they considered to be that core professional remit. Phrases such as "*the champagne service*", "*they need to realize that they're just nurses*" and "*what makes you think you're not a CPN*?" became commonplace. Although I had never been a CPN, the introduction of a generic component to both my and my colleague's job descriptions was clearly an attempt to rein us back in. Around about this time also, opportunities for nurses from our trust to train on the Diploma CBT course, as I and several of my colleagues had done, suddenly dried up. Funding and time away from clinical duties even if the nurse was willing to pay for the course herself was no longer available. There was an unspoken message being given out that formal psychological interventions were not considered to be a core part of the nursing

role. The supreme irony of this was that it was not other professions such as psychiatrists or clinical psychologists who were behind this shift in unwritten policy; it was in fact senior nurses in managerial roles.

To therefore be in a situation where I was teaching the theory and practice of CBT to enthusiastic, self- motivated nurses who were keen to both expand their clinical skills and advance their career, yet at the same time to be on the receiving end of an edict from management that such practice was the domain of other professions and not to be encouraged was disconcerting and disheartening in the extreme. Not only did the research participants have their own battle with identity related negative thoughts as evidenced in the results chapter of this thesis, but they had the additional barrier of the stereotypes and restrictions being placed on nursing practice by some, but not all, managers.

Eventually in an ironic twist, my own situation resolved itself. A new psychotherapy team was created through the efforts of a consultant psychiatrist/psychotherapist and in a recent yet further reorganization of services I was given the post of '*Senior Adult Psychotherapist*' within that team. I will leave the reader to draw his or her own conclusions as to why the word 'nurse' no longer appears in my job title or description.

8.7: Summary of the main conclusions from the research

Finally, this researcher proposes that this work has made a significant contribution to a previously ill-researched yet very important area of the nursing literature, particularly in the field of post-registration nurse education. As well as meeting the initial research aim of developing knowledge and understanding of the experiences of nurses attempting to apply CBT training in their routine clinical practice, the study also offers tangible practical suggestions, grounded in the data as to how future training might be enhanced.

The main conclusions from this study are as follows:

1. External or environmental obstacles to training transfer, already suggested in the existing literature are confirmed for the population under study here.
2. Internal barriers, namely unhelpful, negative cognitions underestimating the self and overestimating the demands of the task are also a mediating factor in the transfer of training.
3. The same phenomenon has been detected in both occupational therapists and students undertaking formal, award-bearing CBT training.
4. These unhelpful, negative cognitions can have their origins in role-dissonance where the core professional identity of the nurse is unable to accommodate the new CBT role.
5. Some nurses training in CBT show evidence of the ability to develop innate strategies, both cognitive and behavioural, which allow them to overcome these internal barriers and progress the application of the CBT approach to their clinical practice.
6. Both the internal, cognitive and identity-based barriers and the means which some nurses devise to overcome them can be conceptualised using a cognitive-behavioural model.
7. The cognitive-behavioural model can be used the basis for a modified relapse prevention module to be incorporated into future training, which the theory suggests will allow trainees to identify and overcome these internal barriers to training and therefore enhance the *real world* effectiveness of that training.

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2: Glossary of Terms

A Priori: *Known ahead of time.*

Andragogy: *A term originally used by Alexander Kapp (a German educator) in 1833, and was developed into a theory of adult education by the American educator, Malcolm Knowles.*

Anorexia: *An eating disorder characterised by low body weight and body image distortion.*

Anxiety disorder: *A blanket term covering several different forms of abnormal, pathological anxiety, fears, phobias and nervous conditions*

Behavioural Therapy: *A form of psychological therapy characterised by a focus on observable behaviour and the role of learning and the presence or absence of reinforcement or reward (see Skinner B.F and Watson J.B).*

Branch program: *Under the Project 2000 training initiative student nurses, both mental health and general first followed a core program before specialising roughly half way through their three-year training and following one of the branch programs (UK).*

Bricoleur: *A person who creates things from existing materials, is creative and resourceful: a person who collects information and things and then puts them together in a way that they were not originally designed to do.*

Bulimia Nervosa: *An eating disorder characterised by a cycle of binging on food followed by purging (most commonly self-induced vomiting).*

Clinical depression: *A state of intense sadness, melancholia or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living.*

Clinical Nurse Specialist: *An advanced practice nurse in either general or mental health, where the focus is on specialist clinical skills.*

Clinical Psychologist: *A practitioner in psychological therapies typically holding a degree in psychology with post-graduate qualification (usually to doctoral level) leading to registration as a chartered clinical psychologist.*

Cognitive Behavioural Therapy: *A psychotherapy based on modifying everyday thoughts and behaviors, with the aim of positively influencing emotions.*

Cognitive Therapy: A type of psychotherapy developed by Aaron T. Beck with a focus on unhelpful or distorted thinking patterns.

Continuing Professional Development: *Continuing professional development is the systematic maintenance, improvement and broadening of knowledge and skill and the development of personal qualities necessary for the execution of professional and technical duties throughout the practitioner's working life.*

Conversational Model of Therapy: *A form of psychotherapy which assumes that symptoms and problemes arise from, or are exacerbated by, disturbances of significant personal relationships. More commonly now called Psychodynamic-interpersonal therapy.*

Core Program: *See Branch Program*

Counselling: *a professional relationship and activity in which one person endeavours to help another to understand and to solve his or her adjustment problems*

E Grade Staff nurse: *A first level qualified nurse under the 1988 revised Whitley Council pay/grading system (UK).*

Family Therapy: *A branch of psychotherapy that works with families and couples in intimate relationships to nurture change and development. It tends to view these in terms of the systems of interaction between family members.*

General Nursing: *The traditional branch of nursing where nurses are primarily involved in meeting the patient's physical (as opposed to mental health) needs (UK).*

Healthcare Trust: *NHS Trusts provide many services of the National Health Service in the United Kingdom. They are not trusts in the legal sense but are in effect public sector corporations (UK).*

Human resources: *The people that staff and operate an organization as contrasted with the financial and material resources of an organization. The organizational function that deals with those staff.*

Humanism: *A broad category of ethical philosophies that affirms the dignity and worth of all people, based on the ability to determine right and wrong by appeal to universal human qualities*

Mental Health Act: *A series of acts of parliament providing statutory guidelines governing the care of individuals diagnosed with psychiatric disorder both in hospital and the community (UK).*

Neurotic disorders: *A "catch all" term that refers to any mental imbalance that causes distress, but, unlike a psychosis or some personality disorders, does not prevent rational thought or an individual's ability to function in daily life.*

Obsessive Compulsive disorder: *A psychiatric disorder most commonly characterized by a subject's obsessive, distressing, intrusive thoughts and related compulsions (tasks or "rituals") which attempt to neutralize the obsessions.*

Occupational Therapy: *An applied science and health profession that provides skilled treatment to help individuals develop, regain or maintain the skills necessary to participate in all facets of their lives.*

Occupational Therapist: *A qualified (usually degree level) practitioner of occupational therapy.*

Pedagogy: *The art and science of educating children and often is used as a synonym for teaching. More accurately, pedagogy embodies teacher-focused education.*

Person Centred Approach: *This is the counselling approach developed by Carl Rogers, and is sometimes for that reason called Rogerian counselling or therapy. It is an approach that recognises the inherent potential of each individual to resolve his or her own difficulties.*

Personal Construct Theory: *A Psychological theory of human cognition most closely associated with George Kelly.*

Pre- Registration Nursing: *Education (including clinical practice) given to nursing students as part of their training to become registered nurses*

Psychodynamic: *Relating to psychodynamic psychotherapy. A model of psychotherapy which centers around the idea of a maladapted function developed early in life (usually childhood) which will, least in part, be unconscious most famously asociated with Sigmund Freud.*

Psychosis: *A generic psychiatric term for a mental state in which thought and perception are severely impaired. Persons experiencing a psychotic episode may experience hallucinations and/or hold delusional beliefs.*

Psychotherapy: *Any form of treatment for psychological, emotional, or behaviour disorders in which a trained person establishes a relationship with one or several patients for the purpose of modifying or removing existing symptoms and promoting personality growth.*

Rational Emotive Therapy: *An active-directive, solution-oriented therapy which focuses on resolving emotional, cognitive and behavioral problems in clients, originally developed by the American psychotherapist Albert Ellis.*

Registered Mental Nurse: *A qualified nurse, specialising in the care of patients suffering from mental illness who has attained registration at level 1 on the UKCC register of nurses and midwives (UK).*

Rogerian: *After Carl Rogers (see person centred approach).*

Royal College of Nursing: *A professional body and union representing the interests of nurses and promoting standards of nursing practice (UK).*

Senior Charge Nurse: *A more modern, unisex term to describe the nursing sister. A qualified nurse with clinical and or managerial seniority.*

Teaching Hospital: *A hospital which provides medical training to medical students and residents.*

United Kingdom Council for Nursing and Midwifery: *The regulatory body which dealt with nursing registration and issues of misconduct prior to it being superseded by the Nursing and Midwifery Council in 2002 (UK).*

3: List of Abbreviations

AR: Action Research

BABCP: British Association of Behavioural and Cognitive Psychotherapies

CBT: Cognitive Behavioural Therapy

CPD: Continuing Professional Development

CT: Cognitive Therapy

GP: General Practitioner

GT: Grounded Theory

OT: Occupational therapy/Occupational therapist

PCLT: Primary Care Liaison Team

RCN: Royal College Of Nursing

RMN: Registered Mental Nurse

UKCC: United Kingdom Central Council (for nursing and midwifery).

4: Semi-structured interview schedule (Cohort #3 OT).

- Preamble: Background to the research, stress confidentiality, usually painless etc

- Unmet need…was that the case for you?

- How far did the workshops go in addressing that?

- Restate area of research interest; ask for participant's experience of trying to apply something of what they've learned in their work (if at all!)

- General how has the experience of trying to apply the training been for you type question (stress *some do some don't I'm not 'checking up!*)

- How user-friendly was the training?

- Any anxieties or doubts

- Some previously have worried about the need to 'get it right'

- Do you allow yourself space to get it wrong to practice to learn?

- What (if any) particular difficulties experienced?

- The 'can of worms' issue

- What would getting it wrong be like/ why would it be wrong?

- Consequences?

- How did it feel saying 'let's try a CBT approach' or did you?

- Any bits of the CBT as taught which felt more relevant than others and why?

- How well does it fit in with patients needs

- How do the patients react to it (positives and negatives)?

- How do you sell the idea to a patient (wee speech?)

- Previous interviews suggest trying to find 'right' patient to begin with is key…..

- What kind of patients seem to suit/which don't suit?

- Laughing in the workshops about having to never ever say "CBT" have you?

- Ever tried written feedback/formulation…if so how did it go/if not why not?

- A few people in the workshops eyes seemed to light up when we talked about collaboration and shared responsibility….how has that worked out?

- How comfortable do you personally feel with the model (check for previous experience)?

- Do you feel legitimate in doing CBT or is it for specialists/experts/psychologists?

- Does it fit in with the OT role?

- How much a part of you usual work is coming up with a treatment plan, actually saying 'I propose to do XYZ to help with anxiety/depression'?

- Other people (esp in medical) raised an issue of lack of time/too many other pressures do get into CBT/Psych issues

- How have management/colleagues responded to workshops

- How do you think they would or how have they reacted to you saying you're going to try a CBT approach with Mrs X

TRAINING OPPORTUNITY

An introduction to cognitive behavioural therapy techniques

A series of 6 half-day workshops designed to give staff a basic understanding of cognitive behavioural therapy

The workshops are open to all first level Registered Mental Nurses and Allied professions (e.g. OT) with an interest in the psychological treatment of depression and the anxiety disorders. The training would be of most benefit to those working in clinical areas where they had access to a mild to moderate client group and had sufficient time to consider incorporating elements of the training into their clinical practice.

Such brief training is obviously not intended to produce fully-fledged CBT therapists but aims to equip learners with the ability to conceptualise patients/clients problems in a CBT framework and perhaps begin to utilise some of these evidence-based techniques learned in their clinical practice

DATES

Monday 1st November 2004 to Monday 6th December 2004 inclusive

TIME

1.30PM 'till 4.30PM

LOCATION

Braan meeting room 2, Murray Royal Hospital

For more inform[redacted]

NB The workshops are being offered as part of an ongoing research project. Attendees will be asked to participate in follow-up interviews as part of the research. This is entirely voluntary and as such participants who choose not to participate are still very welcome to attend the workshops

FIELD NOTES

TEACHING GROUP#1

POST-TEACHING FOCUS GROUP (07/06/01)

PRESENT: ALL (1,2,3,4 AND5)

S.MARTIN (R): INTERVIEWING

S.MARTIN: TRANSCRIBER (11/06/01)

R: "I mean I know this probably sounds a bit vague, what's it actually been like, I mean you asked to come up for the CBT at the start, so you obviously thought that this would be helpful and this was the kind of thing that we need to do. What's it actually been like though, you know, during and after the workshops and trying to put it into practise? How's that been for you?"

1: "I thinks its been good, in respect of its making me query you know when I'm sitting with a patient I'm starting to question you know I can see whether CBT might be good for it, I'm looking at specific things I'm looking at automatic negative thoughts, analysing them more, you know the things my clients are saying, but as well I'm analysing myself and the fact is I think "oh god I need to go and read more about this" because I'm no understanding it all no comprehending it, I find that when I'm looking at the dysfunctional schemata that kinda: (yeah)

1: I find that ye know I can comprehend the rest of it, but sometimes I find it difficult to pinpoint that bit: (yeah)

1: and I keep thinking, "okay I have to go and read more about that, I have to go and read more about that" (right)

1: and I think Ill just over read I think (I know what you mean yeah)

5: I think that's my fear as it were was I've got some knowledge, some information, and trying to then put that into practice (yeah) I'm finding that I maybe need further support, supervision to carry it through and I've got a baseline and I need to then expand on it

R: cos what you're kinda saying is yeah its all good and well that the workshops kinda give you an idea (5:mmm) then you need (2: definitely)

4: it opens up your awareness, yeah that's what its done, its actually made you more aware of what patients are saying to you and things maybe prompts that you should be saying back to them as opposed to just sitting there like a vegetable half the time and just letting them, absorbing what they're saying to you but really having no indication what to give back to them, but when it actually comes to, and this is the way that I feel, when it actually comes to giving them feedback or they're looking at you to wave the magic wand sort of, then start doing something for them, that's when I find that I'm running up against a bit of a brick wall because then I'm beginning to think to myself right "oh Christ what do I do here" and am I doing the right thing?" and perhaps I've just got to go back and look at this like (1) just said and shall read up this or say that or photocopy this then I'm finding that

perhaps I might be doing too much, more than what's actually necessary

R: Because that's almost exactly what you (1) said about the over reading, the reading too much

1: Yeah, but I think its because I feel y'know I've learnt y'know I mean I wouldn't say I'm y'know, I've got some of the theory behind it y'know (Yeah) but I have'nae completely grasped a lot of it and I don't think I ever will y'know because ye cannae know everything but sometimes I just think "is it my own inadequacies oh god right, I should be doing that, but how should I be doing it y'know what format should I follow, how much information should I give, and I think its its really basically what I'm saying is its trying to get confidence in tae using the model and I think that can only come with time, because we only finished the groups maybe about what 3 weeks ago? Or whatever so its to a certain extent its taking on board that knowledge and consolidating it and putting it into practise and I did, I explained the model to one person and I'll go and explain it in a couple of weeks to another person(patients) I feel a wee bit more confident now (R: because you've done it once?) Yeah, but I'm also aware that I'm going to go away, and I'm going to read and I'm gonna write down, I don't know if I'm going to do a formulation initially but I'm gonna

write down in each area what I think the difficulties with this individual are, and then I'll kinda be able to give examples when I go and explain it to her and then it will be more (5: and fit it into the model?) aye to think about it cos I don't think that I'm confident enough to sit there and say "right this is how you are, this is how I see it, this is what you're saying (Yeah) I prefer to go away and think about it first and then come back to the patient

R: Is what you're saying that you like to make sure you are on solid ground before you give it to the patient?

1: Yeah, cos sometimes I don't feel, I feel that as if I haven't quite got a full grasp of the model

5: I think though as well that's its going to take more than 2 or 3 sessions with a patient to find out what their dysfunctional schemata and all that is, you know what their beliefs and attitudes (Yeah) is That's no going to happen straight away, what I'm finding is that when you first see somebody and they sort of highlight their problems, I'm trying to see where they could fit into the model (Yeah yeah) I mean that's about as far as I've got but at the same time, to find out a persons sort of beliefs and all that is longer term but the is the difficulty with us, and I think we brought this up before, that if we're doing sort of short term work, (yeah)

R: so are you actually going to have the time to do this?

3: Most of the time we're more focused on the bottom end of the model, negative thoughts, and maybe recognising them getting them to think of their thinking distortions (Yeah) and then the rational responses. That's more the bit that I've used with the model, and it does seem, its actually quite frightening, If we didn't actually have that knowledge, I'm not sure what we would be doing with patients now, do you know what I mean, because most of them do actually fit into the CBT model (Yeah)

?: They do, that's right

1: But I find now when I'm sitting talking to them and I just, and I think "oh yeah" and before because I didnae know, I mean I knew roughly about CBT but no a great deal and I think "ooh" "I can see where that goes or that goes" so y'know I'm starting to file in my own head

5: I think hear you, its about monitoring their behaviours as well, I mean that's something that I didn't really do before is about how their thoughts are actually affecting their behaviours (right)

1: And it's the whole ethos of patient participation, I like that, because that's what we should be doing (Yeah) and its this getting them to do things (4: collaborate) I wasn't going to use collaboration (laughs indistinct) (R: one of those buzzwords) but I

① EVALUATING POSITIVELY/ POSITIVE AFFECT NOTED THOUGHT IT WORTHWHILE

1 Reacting positively to teaching 1/7

2 Questioning possible appropriateness, 1/7,8 ① Assessing option in session
for CBT Assessing possible usefulness of CBT for this patient, part of decision-making process

? how does she do this - what criteria

3 Focusing on specific aspects 1/9 ① Narrowing the focus
of CBT which might be useful Being specific, considering part of the model, not whole

Rather than just answering is not passive

Going a bit deeper 1/10 ① Deeper than before
(deeper level of analysis) questioning patient's talk, than

5 Reflecting on self especially 1/11,12 ① Focus on deeper
"Process" motivations analysis of what
- increasing self awareness element panned to patients say - tending
To awareness of own motivations.

6. Limited understanding 1/16
shortcoming (understand some b.t. model ① Again CBT model not related
or lack of more than others To equally as a whole
saw it or "pinpoint" Get some bit.
both.

7 Coming up with a solution This happens more
than once. Is caused by
To problem 1/18 anxiety / awareness of motivations.
It's a way of improving It is a solution for
understanding of CBT problem Requires

8 Daunting To read/learn space/time To think
more 1/20

9. Being frightened of applying To practice ① Uncertainty, over having enough knowledge
Soft for own shortcoming/limited knowledge To practice 2/1 Taking a chance
: doubts re model. "leap of faith" Fearing not up To it

10. Recognition of need for further ① Identifying
motivating support 2/3 Workshops not potential solution To problem
enough in themselves - anxiety reduction
To bridge theory/practice gap. - But is not sustainable

11. Having basics of CBT model 2/5 ①
- basics identified as not enough
shortcoming comfortably bridge gap

? what patients say now has "meaning"

pinpoint to expand/open up

- So frame it in CBT terms and find if fit'

12. Opening up awareness of what patients say 2/9 (4) - improved understanding - expanded perception - in session - equating what patients say to theories in teaching

13. Acting as a map 2/11 (4) - increased awareness - suggests direction - let's go this way - road analogy | direction

14. Reflecting on passive nature of previous practice 2/12 (4) contrast to directive - 'like a veg' - unhappy with previous practice

15. Reflecting on ~~feelings of~~ impotence in previous practice 2/13 - caused by ~~lack~~ absence of framework - ~~map~~

16. Expectations of patient 2/16 unrealistic anxiety provoking - transference - they don't know either.

17. Experiencing anxiety and self doubt in context of impotence / patients expectations 2/18 - fearing not living up to patients expectation - not being able to deliver
∴ partially at ready to lead stage.

18. Questioning own practice 2/19 - self doubt - uncertainty, over road to take
"oh christ" - anxious

19. Looking for ways to (4) improve on knowledge base 2/21 - seeking more certainty to alleviate anxiety - working on assumption he does not know enough.

20. Being aware of not of overcompensating for perceived shortcomings. 3/1 (-) - lacking clear guide to how good do I have to be - how much do I need to know to do this
FUELED BY ANXIETY.

21. Predicting she will never fully understand CBT theory 3/8 - she believes she has limits to how much she will understand
placing some aspects of model as beyond her reach - again model seen as being able to break into bits

22. Questioning own competency in practice 3/9
Self doubt - anxious - am I good enough - what

[Margin notes: "is this a code of its own?" beside items 11–12; "process" beside item 13; "not knowing where to be / tell them?" beside item 17; "what would inadequacies be?" beside item 22]

later in process i.e. aware that CBT is an option but not sure how to

23. Expressing uncertainty over how to put the model into practice 3/10 — Unsure what / explanation to give the patient — lacking confidence.

24. Reasoning with self that competence and confidence only come with time 3/14 — Trying to rationalise / overcome anxieties — Moving away from self criticism — Developing awareness of a process which takes time / teaching integration.

25. Recognising a need for a consolidation period 3/16 — Developing awareness of stages in process which learner needs to go through.

* 26. Gradually incorporating model into practice. 3/17 — The Process is gradual

\+ 27. "Trying it out" 3/18 — won't get it right 1st time — need to learn from experience — need to practice.

* 28. Recognising need for reflection whilst gradually incorporating model 4/1 — again, process — Try — think about it — approach, a bit at a time — radar chart / flowchart

29. Needing time to think 4/7 — making sense of info from patient before going down CBT road — don't feel able to think on her feet!

30. Need to become more confident with fit of model to patient's stated problems before feeding CBT formulation back to patient 4/8 — or suggest framework to patient.

*

31. Not feeling confident enough to offer formulation immediately 4/7

32. Making sure they are on solid ground 4/8

Trying to allay own anxieties by developing respect for process.

33. Coming to terms with need for time to develop comprehensive formulation. 4/12

Some bits of the model take longer than others to

34. Trying to fit patients problems into CBT model 4/17 "Trying to fit" (as far as I've got")

1st stage process

35. Expressing doubts over whether or not they have time to fully apply model due to job constraints 5/1

Some aspects of model more relevant to their clinical circumstances than others due to time

36. Focusing on one bit (bottom end) of model more than others. 5/2

* THOUGHT / FEELING / BEHAVIOUR SEEMS A LOT MORE RELEVANT AND PRACTICAL TO THEM THAN SCHEMATA / ACTIVATING EVENTS - ALSO MORE PRACTICAL DUE TO TIME CONSTRAINTS *

37. Recognition of absence of any previous or alternative model which they might use 5/6 Added value to workshop

- motivation to accept model as no obvious alternative

38. Recognition of relevance of model to most cases (fit) 5/9

the CBT seems a plausible model as a explanatory model to problems / [illegible]

39. Beginning to frame what patients say in CBT terms 5/11
- revelation - recognition 'now I see it' - got the gauges!

~~40~~ 172 4/19 bottom end of model more suited to them I

influence of Teaching on scenario [illegible]

40. New awareness of (cause) change in perception and (effect) for thought, and consequence behaviours 5/16 - explore further more / deeper

41. Identification with the collaborative nature of CBT model 5/19. ~~[illegible]~~ Consequence being encouraging patient to be more involved. fits with nurses perception of how dimensions should be

42. Recognition of match between ethos of CBT model and client group in terms of their "active involvement" 6/1 This match not just nurses but patients too consequence - reinforcing

43. Workshops acting as a refresher course 6/7 - explanation of why how consequence - reinforcing validating practice

44. Workshops acting to put practice and theory into context (5) 6/13

45. Uncertainty over what constitutes formal CBT 7/2 whether seems to average CBT is all or nothing — how do they view CBT?

46. Vaguely using CBT 7/3 not seeing herself as doing full blown CBT

47 Patients reacting positively (identifying) with CBT model simplicity and relevance 7/5 moment of revelation pt gets it but nurse has to get it 1st

48. Putting the pieces of a jigsaw together 7/9 1st need to make sense yourself ~~then~~ fit pieces in nurses head then give finished picture to pt

49 Patients positive feedback (identification) with model reinforcing therapist / nurse 7/1[illegible]

Feedback loop [illegible]

Categories. I

(1) Satisfaction with Teaching (1) (15) (36)

* (? broader - trying to make sense of the work) *

(2) Evaluating whether (all) patients (problems) fit CBT model or not (2) (29) (34) (48) (75).

(3) (? subcategory of (2)) Selecting part of the model to fit a patient's amount of her problem, (3) (35) (42) (122) (84) (98)
(45) Subcategory [illegible] parts that fit less well (73) (88) (89)

(4) Going deeper with analysis (4).
(link to increased awareness (8))
subcategory (40) (65) (67)

(5) Experiencing anxious feelings (5) (9) (102)
(16) (subcategory - being aware of patient's expectations)
(17) (18) (22) (23) (31) (57) (60) (61) (97) (105)
(Subcat - self doubt) (72). (109) (113) (114) (115) (93) (94) (101) (118) (119)

(6) Understanding model (6) (44).
(subcategory - partial) (11) (31)

(7) Finding a way forward ~~(7)~~ ~~(8)~~ (19)
This is in (Subcategory - out of session. (109 - link 11)
move to anxious feelings solution to problem.
(Subcategory doing CBT on self (24)
(121) (Subcategory - solution not have access to (10) (25) (28) (32) (117)
(33) (89)

Categories III

(8) Increased awareness (12) (40) (63)
(link to going deeper with analysis (4)) (39) (50)
(67) (81)

(? overall category)

(9) Being more active. (13) (BROADER)
Structured (52)
Useful + relevant (53) (77)
Challenging (63)

(10) Reflecting on shortcomings of / Contrasting with
pre workshop practice (14) / previous practice.
(15) (37) (51) (54) (59) (67)

(11) Trying to ~~find~~ balance (20) (25) (33)
(46) (99) (109 - maybe different cat) - link (7) (112) (118)

(? perceived?)

(12) Coming to terms with (limitations) (81)
(link to (5) + (7)) (95) (97) (108) (111) (50)
(116) (118)

(13) Consolidating learning (25) (29) (52)
(56)

(14) Beginning to incorporate teaching
into practice (26) (27) (28) (45) (46) (56)
(subcategory - "trying it out") (89)
associated with anxiety (51) (57)

(15) ~~Learning~~ to pace self. (33) (part of 16 balance)
(17)

CATEGORIES III (need broader category)

(101) (102) (127)

workshop content

(16) Trying to fit ~~demand~~ ~~yet~~ into job constraints (100) (107) (105) (35)

- broader category inc match (41) (91)

(more than relevant illustrating)

(17) Seeing COT model as relevant (38) (88)
? identify with (Link with (2) "F.T") useful (81) (52) (65), (92)
(86) (Subcategory - relevant to them as clinician) (71)
less good fit (73) ~~(74)~~ clients (42), (68) (69) (79)

(18) Moments of revelation (Link with (2) "F.T") Affective component "ooh" | SPLIT (39) Patient side too. (47) (84)

(19) Validation ? Confidence (43) (69) (70) (85) ~~(86)~~

is (2)

(20) Bigger core here of trying to work out if COT is an absolute ~~or can it be "diluted" according~~ * to need / ability / confidence " (46)

(21) Getting ~~positive~~ feed back from patient
Positive (47) (49) (62) ~~(78)~~ (83)
Negative (78)

(22) Giving the patient feedback or making sense of it for the patient (48)
(81) (83) (84) (67) ~~(88)~~

CATAGORIES IV

(23) how about a broader "opening up" catagory (77) . (78) 78 or breaking down barriers
(67) (79) (116) (80) (81) (83) (85)

link.

(24) Experiencing difficulties applying teaching
(71) . (Subcatagory patients problems)
(73) (74) (87) .

(25) ? Broader sharing with patients rest
(79) (80) (81) (83) (85)

(26) Questioning role within context
of wider service (94) (105) (106) (115)

(27) Dealing with own needs.
(117) (look back for more) (links to "way forward")

(28) Unhelpful strategies
(120)
– as a consequence
of (5) "negative feelings"

POST TEACHING / PRE PRACTICE

(General perception: relevant / increased anxiety) / (some understanding limited / varies / causes threat (overcome (finding way forward) by feedback)

also from feedback loop?

Choice is partly about clinical considerations also though personal ones. Clinical not manageable ...

CLINICAL SITUATION (WITH PATIENT)

CHOICE

(evaluation: fit / explore more patients characteristics & relationship "difficult")

NEGATIVE FEELINGS (THREAT)

NO

No IMMEDIATE "BEGINNING" CAT POSSIBLE

DO SEPARATE (feedback)

(Either involves environment / Tries to create / creating safe)

SELECTING PART

(↓ anx (more manageable) blurs "what is CBT"? (? do they announce CBT?)

FIND BALANCE (uncertainty expectation)

LIMITATIONS / IDENTITY

CAT(S)

Change in role (contrast with previous) (passive less responsible,

Difficulties ("when to do ? what!)

Role in wider service

Bumpmore ... (anx)

"CONSOLIDATE" LEARNING

CONSOLIDATION

REASSURANCE

VALIDATION

GETTING / GIVING } FEEDBACK

OPENING UP

x BREAKING DOWN

WHERE WIDER IDENTITY FIT (need structure).

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(4) Going Deeper

TM/CODE: Going a bit deeper (4)

Causal Condition: Impasse in clinical work / muse willing to breach barrier i.e Take a chance. Increased confidence (in self? relationship) Positive feedback: 'Wrong' 'right'?

Context: Attending to apply CBT approach testing out: knowledge/ability/patient

Intervening conditions: Confidence Fault in self/ability. Able to see usefulness/relevance of CBT model - opportunity

Action Strategies: offer verbal formulation / Describe CBT Give example "some people find" → impose some structure

Consequences: Possible positive reinforcement Possible "failure" - rejection Possible ending up and breaking down" therefore go deeper!

Interact Memo's Comparison with Categories F.G.H.Z - F.G.H.I

⑥. Finding Way Forward / Solution

Overall this seems to be about a shift from the academic / conceptual to the real life / pragmatic.

With the academic / conceptual seem to come pressures i.e. living up to the positives of CDS.

Most of the way forward solutions involve setting aside these pressures by refocusing instead on more down to earth terms. This allows a renegotiation of the nurse / patient role as more equal + collaborative rather than expert.

Obviously this notion of CDS / expert is a distortion but it is how the nurses feel

Even adopting the bottom-up approach is part of this - moving away from the experts just knowing + understanding

The way forward therefore is largely about shanking or reducing the dissonance which inhibits.

I think therefore this is a meta-category

solutions to problems

(7) Finding a way forward

This category seems to divide into two (?3) subcategories:

(a) "Doing" solutions: i.e taking time to think, doing additional reading (From 92(6) Having a repertoire would be a way forward

(b) adaptive solutions: using only part of the model, simplifying the approach to meet the patients needs and illustrating the model with real life examples relevant to the patients story.

(c) Challenging their own negative thoughts, questioning need to be expert, accepting limitations, allowing self time to develop assessment and formulation

(need to be expert in everything)

Also very important is sharing responsibility with the patient - moving away for expert to facilitative/collaborative role. This helps ameliorate nurses anxieties about their own limitations. Also tied in here is nurses often admission to patients "I don't know". Link to 'breaking down barriers' (23).

There is a suggestion for one nurse that most barriers, hence most solutions or ways forward are INTERNAL

example of challenging own N.O.T. as 2 (10) self blame for client not engaging beginning to recognise some will not and that client may choose not to

Comparison to other categories:

(1) Done
(2) Done
(3) Done
(4) Done
(5) Done
(6) Done
(7) 0
(8) Increased awareness: ?
(9) Doing more active ?
(10) Contrasting with previous practice ?
(11) Trying to find balance: This is a key solution to a whole class of problems and involves the nurse attending to moderate expectations of themselves as well as the process of change in general & more realistic
(12) Coming to Terms with limitations: partly much as per (11) Coming to Terms means 'accepting' making allowances for self ie to okay not to be 'expert' know everything

⑦ Finding solutions to problems (II)

⑬: Consolidating learning: The safe environment the nurses need to create for themselves as part of this integration can only really be achieved by ⑫ and ⑪ i.e allowing themselves time and space to develop and learn.

⑭: Begins to incorporate Teaching into practice: Partly much covered by ⑪ ⑫ ⑬

⑮ Trying to integrate Teaching within constraints of service. There is evidence for outside the study that the nurses have yet to really find a solution to this issue.

⑯ Seeing CPS model as relevant: ?

⑰ Moments of revelation ?

⑱ Validation: ?

⑲ Getting feedback for patients: This does help the nurse develop understanding, accurately assess their own understanding of the model etc and so attain some answers. It is not however employed as a solution to specific problems SHOULD IT BE!!?

(20): Giving the patient feedback
The aforementioned solutions
i.e 'coming to terms', finding balance
'consolidating learning' etc seem
to be required to give the
nurse the confidence to begin to
give the patient feedback.

(21): Opening up and breaking down
barriers: ?

(22): Experiencing difficulties applying
the Teaching: (-) with (12)
'Balance' this seems to be
about the nurses coming to accept
that difficulties the patients have
in engaging may not be due to
their incompetence / inadequacies.
Strategies to overcome this problem
include (3) identifying comfort / models:
(11) 'balance'
(12) Coming to terms with
limitations.

(23): Questioning role within wider service:
The solution to this issue seems
to be about creating an
identity / which they feel comfortable
with and which they feel other
colleagues would accept. Some of
the nurses have suggested that the
difficulties are more with their own
insecurities rather than any genuine

Comparisons with F.G. H1 Categories

Finding ways forward / solutions to problems

F.G. #2

(2) Focusing on part of the model (the vicious circle) as a way into therapy

(4) 'Yes practice is a way of helping confidence, but allowing one's self space to make mistakes is the key psychological adjustment'

(7) Using peer support as a way to ~~[illegible]~~ cope with ~~unhelpful~~ pressure from outside

(8) Allowing self not to know, almost going the other way from belief should be expert to - I haven't a clue.

All lifting expectations from self

(10) Aware now of unrealistic / unhelpful 'need to produce' - able to challenge & reframe that.

(11) Reducing perceived expectations for patient simultaneously enlisting them in shared responsibility (collaboration)

(19) reflecting on probability that might of expectations would not be so easy to set aside on a ward setting

(18) Declaring a well rehearsed script or repertoire is a useful way to overcome anxiety

(20) Not inviting CDT talk but reading to patients story is a subtle way of dealing with emotions of CDT. Do not have to announce it or set self up (to arrest incorrect)

(21) Using a written model is a way of bridging the gap before model is internalised. Can recognise, but doubts over whether can produce it.

(23) Slowing up / breaking down the flow of information into manageable chunks - easier to make sense of

(24) Using patients language mutually beneficial including dejargonising moves away from emotions CDT into better to patients

(13) reflecting on probability that weight of expectations would not be so easy to set aside on a ward setting

(18) Declaring a well released script or repertoire is a useful way to overcome anxiety

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* BE/SCARE

(23) Slowing up / breaking down the flow of information into manageable chunks - easier to make sense of

(24) Using patients language mutually beneficial including dejargonising moves away from emotions of CBT relates better to patients

? ISSUED WITH THERAPEUTIC RELATIONSHIP AS A CAT OR DIVISION POINT. MAJ.

Strategies used in Finding a way forward/Overcoming difficulties: ~~META~~ CATEGORY:

CONTEXT WITH OTHER CATEGORIES:

Beginning to apply the teaching i.e. the first attempts to work with patients using a CBT approach brings the nurse up against various **problems** including their own emotional difficulties created by **unhelpful beliefs**. The strategies described here help to **overcome** these barriers to the transfer of training, allowing the nurse to begin the process of active collaboration with the patient, leading to consolidation of their knowledge base **(understanding)** as well as beginning to reduce the dissonance in their role **identities.**

SUMMARY:

These strategies comprise mainly of a series of psychological adjustments, which the nurses make to varying degrees in order to shrink the perceived dissonance between themselves, their abilities, their core role identity and the perceived demands of applying a CBT approach. The nurses all display keen self-awareness of the underlying assumptions on which the dissonance is based. Through both private reflection and peer support they modify these assumptions to, in effect give themselves less of a mountain to climb. The adjustments fall readily into 2 main sub-categories namely; taking CBT itself down from its pedestal thus making it more manageable/less daunting and secondly, re-evaluating (moderating) their expectations of themselves as well as beginning to acknowledge the skills and abilities which they already bring to their work. There is a final category of more pragmatic (non-psychological) solutions.

+1,7 Good Theme!

Sub Category: ***Taking CBT off its pedestal*** (PSYCHOLOGICAL STRATEGY)

The nurse here is consciously refraining from using the term 'formulation' (1) despite describing a virtual textbook account of a formulation

The nurse here is holding back from describing her way of working with a patient as 'CBT' because of a belief that CBT 'proper' is done by 'therapists (2)

DOING CBT SEEN AS THREATENING SO DON'T CALL IT CBT!!

Example of the nurse avoiding the taught CBT terminology 'more of a hypothesis' rather than 'formulation' (3)

Here the nurse seems very uncomfortable about using the term CBT to describe their interventions with a patient but goes on to describe what amounts to a CBT approach. This seems to relieve the perceived weight or gravitas of CBT from the proceedings (4)

The nurse lacks the confidence to explain the CBT model to the patient 'cold' and upfront and so waits until the patient has given their account of things so the nurse has 'material' to then make CBT like connections but using the patient's own terms of reference. In essence reacting to the patient rather than initiating the concept (5)

Dejargonising the CBT terminology, using more normal day to day language as well as the patients own terminology, which makes both the nurse and the patient feel less intimidated and is probably easier to relate to (6) (7) (8)

Using a CBT approach without introducing it to the patient as 'CBT' (9)

Encouraging the patient to diary keep in attempt to allow them to see the cause and effect relationships effectively facilitating the patient making the connection without the nurse having to make if for them. Good CBT practice but also takes the pressure off the nurse. (10)

The nurse selects part of the CBT model which she perceives to be more relevant and easier to understand as a way of breaking down the CBT approach into 'bite-size' chunks (11)

Beginning to accept that a CBT intervention is not necessarily right for every patient reframes CBT as a tool to be used where appropriate. (12)

Sub Category: ***GETTING COMFORTABLE IN OWN SKIN:*** (PSYCHOLOGICAL STRATEGY-1)

The nurse is reframing what it means to her to not know something and to have to ask for advice from her peers. Previously she felt shame that she didn't know, now she views not knowing and asking as a normal part of development (13)

The nurse here is reframing her view of the situation where a patient asks her something and she doesn't have a ready answer. Rather than seeing it as failure she seems now to be viewing it as inevitable, something to readily admit to the patient, an opportunity for learning and a way to break down the barriers between nurse and patient i.e. we are here to learn together. (14)

The nurse here is allowing herself space and time to arrive at an understanding of the patient's problems rather than instantly having to come up with an explanation and cure (15) (16)

Here the nurse is setting realistic expectations of what her involvement with the patient will entail and what the nature of the relationship will be i.e. collaborative rather than being set up as the expert (17)

The nurse is aware of setting unrealistic expectations of himself. He reframes the experience of possibly having to refer a patient on to a more specialised service from a sense of failure to a clinically appropriate and indeed helpful decision. (18)

Beginning to recognise that the client shares in the responsibility for engaging and that it is not therefore all the nurses' responsibility to 'make it happen' (19)

Learning to tolerate not knowing, accepting that there are times when you have to just go with the flow of treatment and see what emerges (20)

Peer support allowing nurse to recognise that to be unsure and that other nurses/therapists all struggle from time to time helps allay the tendency towards unhelpful self-criticism. (21)

The nurse here is beginning to recognise that he can offer a CBT approach as part of a generic remit and therefore does not have to be a specialist to do so. This reduces role dissonance and frees him up to go further. (22)

Sub-Category: *PRAGMATIC STUFF.*

Using a diagram of the model as an external aid to understanding the fit and flow of the model whilst the nurse lacks a stable and complete internal representation to refer to whilst attempting to understand the patient (23) (24)

Rehearsing and developing a repertoire of things to say and approaches to try with patients rather than having to reinvent the wheel every time.(25)

Writing down a hypothesis as a useful exercise to help crystallise the nurses understanding of the patients problems (here only being used for the nurses own purposes) (26)

Buying a book that has a more pragmatic/patient orientated stance (27)