



An Exploration of Cognitive Behavioural Therapy Training

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Doctorate in Clinical Psychology

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List of Contents

List of tables.....	3
List of figures.....	3
List of appendices.....	4
Thesis abstract.....	5
Declaration.....	6
Acknowledgements.....	7

Paper 1: The Experience of Cognitive Behavioural Therapy Training: A Mixed

Methods Systematic Review

Abstract.....	9
Introduction.....	10
Method.....	13
Results.....	24
Discussion.....	34
References.....	37

Paper 2: Exploring Cognitive Behavioural Therapy Diploma Students’

Construal of their Personal and Professional Development

Abstract.....	43
Introduction.....	44
Method.....	48
Results.....	53
Discussion.....	58
References.....	64

Paper 3: A Critical Evaluation and Reflection of this Research

Introduction.....	72
Paper 1: The systematic review.....	72
Paper 2: The empirical paper.....	78
Personal reflection on the overall research process.....	91
Personal reflection on my own experience of professional training.....	94
Conclusion.....	98
References.....	99

List of Tables

Paper 1: The systematic review

Table 1: Summary of papers included in the systematic review.....	18
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Paper 2: The empirical study

Table 1: List of elements.....	51
Table 2: Mean Euclidean distances for element pairs.....	54
Table 3: Examples of constructs created for each category from the Classification System for Personal Constructs.....	56
Table 4: Constructs categorised using the Classification System for Personal Constructs.....	57

List of Figures

Paper 1: The systematic review

Figure 1: The Declarative Procedural and Reflective Model.....	11
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Figure 2: A PRISMA flow diagram describing the search process.....	15
<i>Paper 2: The empirical study</i>	
Figure 1: Model of the influences on self-perception of competence.....	46
Figure 2: The experience cycle.....	60

List of Appendices

Appendix 1: Author guidelines for the Behavioural and Cognitive Psychotherapy Journal.....	106
Appendix 2: The Quality Assessment Tool for Studies with Diverse Designs.....	114
Appendix 3: Quality assessment rating scores of the reviewed papers.....	118
Appendix 4: Author guidelines for the Journal of Clinical Psychology and Psychotherapy.....	122
Appendix 5: Ethical approval.....	128
Appendix 6: Participant information sheet.....	130
Appendix 7: Consent form.....	134
Appendix 8: Demographic information questionnaire.....	136
Appendix 9: Debrief form.....	138
Appendix 10: Classification System for Personal Constructs.....	140

An Exploration of Cognitive Behavioural Therapy Training

Hannah Jenkins

Doctorate of Clinical Psychology, Cardiff University, 2017

Thesis Abstract

This thesis contains an exploration of Cognitive Behavioural Therapy (CBT) training. Paper one consists of a systematic review of 13 studies exploring the experience of CBT training. Findings were categorised into four themes; the exploration of Self-practice/Self-reflection, internal processes throughout CBT training, perceived effective components of CBT training, and general satisfaction with CBT training. Overall the findings concluded that CBT training is experienced in a relatively positive way, however, the journey can be difficult for students at times. The review revealed a clear gap in the literature regarding the general experience of CBT training, with no imposed focuses or pre-conceived themes. Implications for students, training course providers and commissioners are discussed. Paper two describes an empirical study conducted on eight students pre and post their postgraduate Diploma in CBT. Personal construct theory and the repertory grid technique were employed to capture students' experience of training and their construal of their personal and professional development. Findings reported that whilst participants construed themselves as closer to 'desirable' elements post training, these differences were not statistically significant. A statistical difference was observed however, in participants' perception of an 'Ideal therapist' post training. Implications for CBT training programmes are discussed and findings related to the political context both in Wales and the rest of the UK. Paper three presents a critical reflection and evaluation of the first two papers, including the authors' personal reflections on the research process overall and her own experience of postgraduate, professional training in Clinical Psychology.

Declaration

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is being submitted concurrently in candidature for any degree or other award.

Signed (candidate) Date

Statement 1

This thesis is being submitted in partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology.

Signed (candidate) Date

Statement 2

This thesis is the result of my own independent work/investigation, except where otherwise stated, and the thesis has not been edited by a third party beyond what is permitted by Cardiff University’s Policy on the Use of Third Party Editors by Research Degree Students. Other sources are acknowledged by explicit references. The views expressed are my own.

Signed (candidate) Date

Statement 3

I hereby give consent for my thesis, if accepted, to be available online in the University’s Open Access repository and for inter-library loan, and for the title and summary to be made available to outside organisations.

Signed (candidate) Date

Acknowledgements

Firstly, I wish to take this opportunity to show my gratitude to the participants who took part in this study. They willingly gave up their time on two separate occasions, and were open and honest about their own experiences. I wish you all the best for your future careers, and hope your personal and professional development continues to grow throughout your journey to full accreditation.

I would like to thank my 'team' of research supervisors, Dr Louise Waddington, Dr Nicola Thomas and Dr Dougal Julian Hare for their invaluable input to all aspects of this thesis and for generously giving their time to provide much needed advice, expertise and encouragement throughout this process. I would also like to thank Josephine Allen for being my independent assessor for the systematic review.

To all my clinical placement supervisors; thank you for acknowledging the stress of juggling academic and clinical work, and providing me with the opportunities to pursue both simultaneously.

Finally, my special thanks to my husband, Luke and my parents, Ann and Steve. Without their unconditional support, 'cheerleading' skills and regular reminders to always strike a 'work-life balance', this thesis would not have been possible. I hope I have done you proud.

Paper 1: The Systematic Review

The Experience of Cognitive Behavioural Therapy Training: A Mixed Methods Systematic Review

Manuscript prepared in accordance with the guidance for the
Behavioural and Cognitive Psychotherapy Journal (see Appendix 1[†])

Word count (excluding Tables, Figures and References): 5000

[†] References to appendices will be removed prior to submission for publication

Abstract

Background: Research in the field of Cognitive Behavioural Therapy (CBT) training has primarily focused on the acquisition and development of skills and competence. Little is known regarding the experience of training from students' perspectives.

Aims: This systematic review aimed to review and critique the research conducted on the experience of CBT training.

Method: Four electronic databases were searched for published studies reporting on the experience of CBT training. Thirteen articles were selected based on pre-determined inclusion and exclusion criteria and were assessed for quality using the Quality Assessment Tool for Studies with Diverse Designs (QATSDD, Sirriyeh, Lawton, Gardner and Armitage, 2012). Due to the lack of consistency in the study designs and outcome measures used, a narrative synthesis of the findings was conducted.

Results: Findings were categorised within four themes for synthesis; the experience of Self-practice/Self-reflection, internal processes throughout CBT training, perceived effective components of CBT training and general satisfaction with CBT training.

Conclusions: Overall this review was able to draw conclusions regarding the experiences of aspects of CBT training from relatively good quality research; however, the review revealed a clear gap in the literature regarding the general experience of CBT training, with no pre-conceived themes or imposed focuses.

Key words: Cognitive Behavioural Therapy; Training; Experience.

Introduction

Research into the efficacy of Cognitive Behavioural Therapy (CBT) as an evidence-based treatment has increased in recent years, leading to a need for good quality training in the model's theory, application, and supervision (McManus, Westbrook, Vazquez-Montes, Fennell and Kennerley, 2010).

The literature on CBT training has focused on its effectiveness by the means of assessing trainees' skill acquisition and competence, post training. McManus et al. (2010) examined the levels of CBT skill in 278 trainees pre and post a postgraduate Diploma course in CBT. The study utilised written assessments marked by course staff and scores on the supervisor-rated 'Cognitive Therapy Scale' (CTS, Young and Beck, 1980, 1988). Results found that Diploma students' competence in CBT increased, as measured by scores on both academic assignments and supervisor ratings of clinical skill, suggesting that Diploma-level training in CBT is effective for skill and competence acquisition.

In a randomised trial, Beidas, Edmunds, Marcus and Kendall (2012) examined the effectiveness of one-day workshops in CBT for anxiety among youths, focusing on therapist adherence, knowledge and skill. Participants were randomly assigned to one of three training modalities; routine training, computer training and augmented training (emphasising active learning). Findings concluded that the one-day workshops only produced limited improvement in therapist adherence, but that further consultation after training significantly predicted higher skill and therapist adherence at follow-up. Participants were more satisfied with the augmented training modality, focusing on active learning. This study suggests that one-day workshops are not sufficient to change therapist behaviour; further post-training consultation and supervision is required and participants preferred 'active training' modalities.

In 2006, Bennett-Levy described a cognitive model to provide a deeper understanding of how therapists obtain their skills. The Declarative Procedural and Reflective model (DPR) visually explains the process of acquiring knowledge through training via three interacting systems (Figure 1). Firstly, the declarative knowledge system describes factual knowledge gained through reading and attending lectures. Secondly, the procedural knowledge system refers to declarative knowledge paired with knowledge gained through experience. Finally, the reflective system, referred to as the “engine” of the other two systems, is activated for complex cognitive tasks such as problem-solving and utilising previous knowledge and experience to guide future guidance and perspectives. The model provides a useful framework to understand the mechanisms of acquiring skill; however, the trainee perspective and experience of training is not a focus of this model.

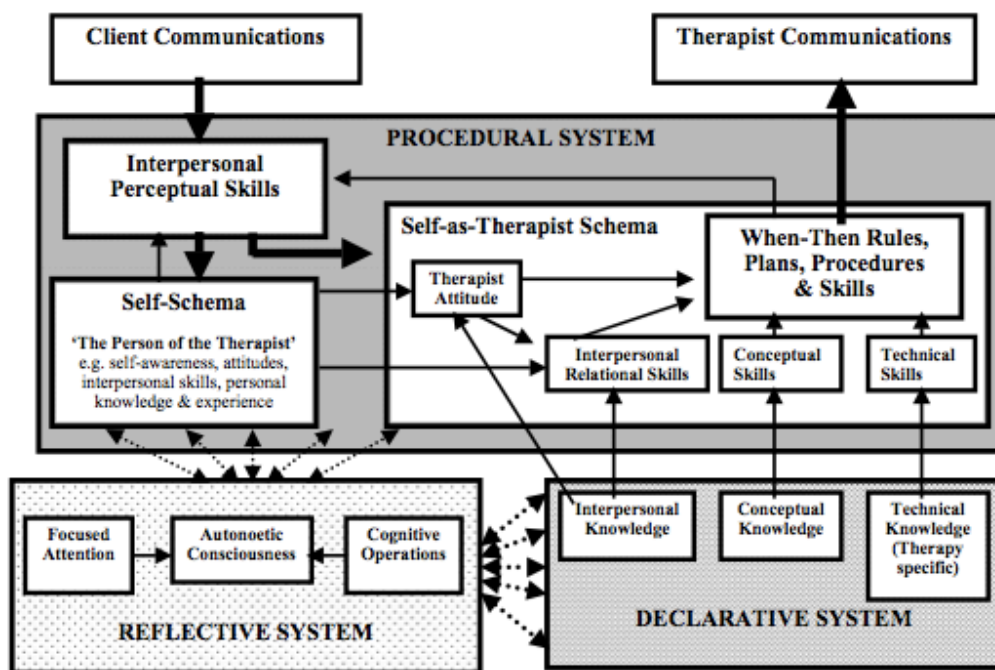


Figure 1. The DPR model of therapist skill (Bennett-Levy, 2006).

Within the literature, systematic reviews have been employed to explore elements of CBT training – primarily focusing on competence. Muse and McManus (2013) conducted a systematic review on the methods of assessing CBT competence. A total of 10 methods of assessment were identified across four levels; knowledge based assessments (such as essays and multiple choice questionnaires), assessments of practical understanding (including case reports and short-answer clinical vignettes), assessments of practical application of knowledge/skill (such as role-plays) and clinical practice assessments (including assessor-rated treatment sessions, supervisory assessments therapist self-assessment and patient outcomes). Strengths and limitations of these methods were described in the review, and tentative conclusions drawn, suggesting the most robust measure of competence comes from assessments based on direct observation of treatment sessions.

Rakovshik and McManus (2010) reviewed the available research to establish an evidence-base for CBT training. They reported that more extensive training leads to increased therapist competence, which positively related to patient outcomes. By contrast, stand-alone workshops and CBT manuals do not significantly improve therapists' skills or patient outcomes. The review also reported on the considerations of long, costly training programmes and concluded that as training is expensive, a wider dissemination of CBT to other staff may be necessary to maximise the financial investment of training. They concluded that more scientific studies focusing solely on CBT training is needed, as much of the available research is often obtained as a 'by-product' of studies exploring the dissemination and treatment of CBT.

Whilst the literature on CBT training is growing, a summary of what it is currently known about students' experiences of CBT training is not available. This systematic review provides a review and critique of the available literature on the experience of

CBT training. The term ‘experience’ was interpreted broadly to capture the variation within the literature.

Method

Search strategy

Electronic searches of four databases (PsycINFO, Medline, Embase and Web of Science) were conducted in March 2017 and reviewed in April 2017. The first search terms used were ‘cognitive behavioural therapy’, ‘cognitive behaviour therapy’, ‘cognitive behaviour therapy’, ‘cognitive behavioural therapy’, and ‘CBT’, combined with the Boolean operator ‘OR’. Both the UK and US spellings of ‘behaviour(al)’ were used for the first search term. The second search term was ‘training’ and the third was ‘experience’. All three searches were combined with the Boolean operator ‘AND’ to produce the completed searches.

Inclusion / exclusion criteria

Studies were included if they were published in a peer-reviewed journal and focused on any aspect of CBT training, from students’ perspectives. Studies published before 1990 were excluded as it was agreed that as CBT training was more formally established from this time (mainly due to the growth of the British Association for Behavioural and Cognitive Psychotherapists, BABCP and the implementation of its accreditation standards and procedures) and any literature prior to this date may not be representative of CBT training in more recent years. Studies not available in English language were excluded, along with grey literature. Studies that solely

explored the acquisition of competence, knowledge and skill during CBT training were deemed not relevant to this review on the wider experience of training.

Search outcome

Following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance (Moher, Liberati, Tetzlaff, and Altman, 2009), the systematic review was undertaken (Figure 2). The four searches yielded a total of 1494 records. Removal of duplicates left 1075 titles and abstracts, of which 1043 were deemed irrelevant, leaving 32 full-text articles to assess for eligibility. From the full-text screening, 19 articles were excluded. This left 13 studies remaining for quality assessment.

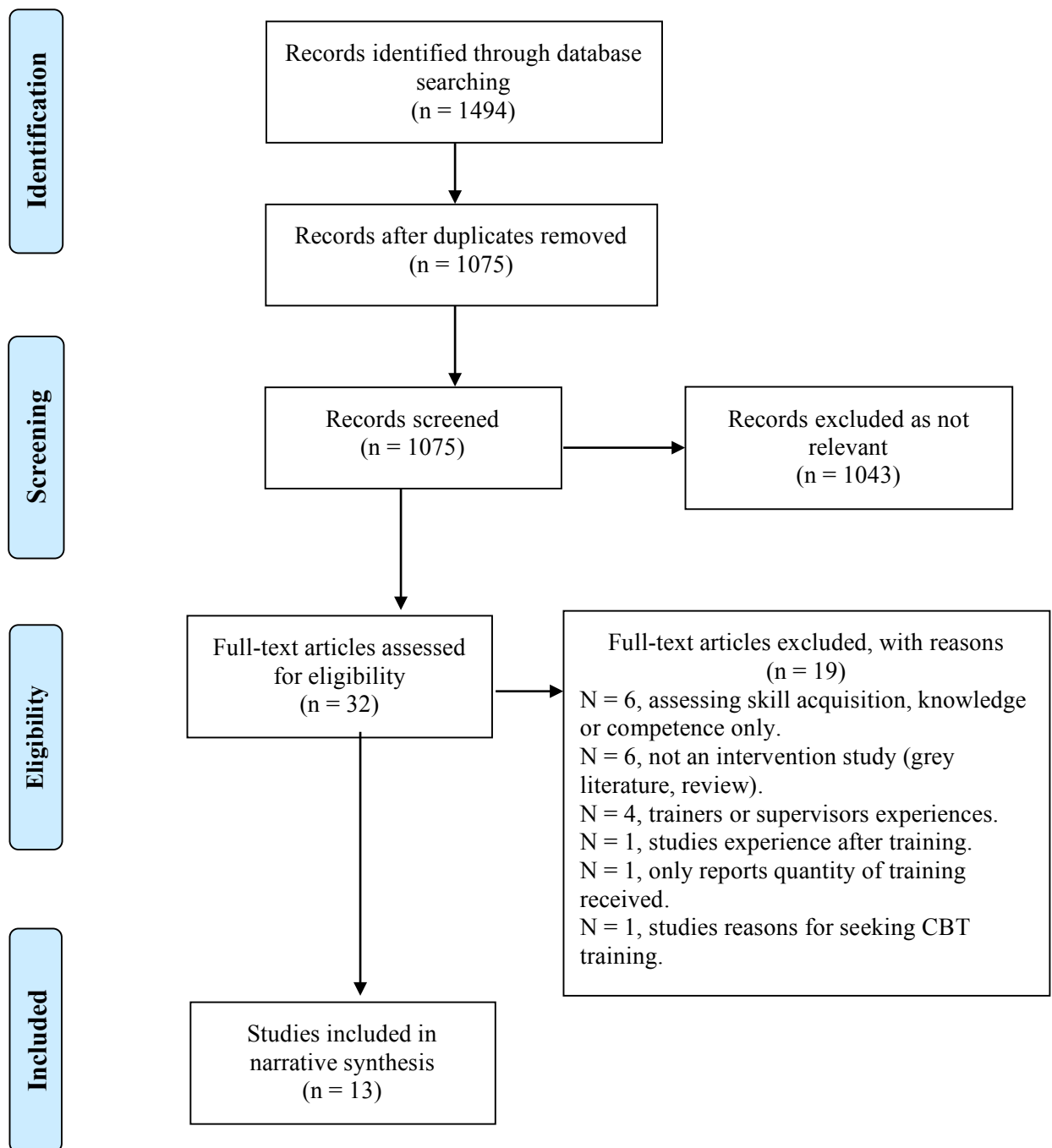


Figure 2. PRISMA search flow diagram.

Quality assessment

The 13 identified studies were reviewed for their quality using the quality assessment tool for mixed methods systematic reviews (QATSDD, Sirriyeh, Lawton, Gardner and Armitage, 2012, see Appendix 2). The tool comprises of 16 criteria, 14 applicable to quantitative studies, and 14 applicable to qualitative studies. The QATSDD was

chosen as it reports on both methodological and reporting criteria, and has been shown to have good-substantial test-retest reliability. Each study was given a score (0, 'not at all', 1, 'very slightly', 2, 'moderately, and 3, 'complete') for each relevant criterion. Total scores were then converted into a percentage to produce a descriptive quality assessment percentage (100-75% = 'high quality', 74-50% = 'moderate quality' and 49-0% = 'poor quality'). All papers were quality assessed by the first author (HJ, see Appendix 3 for ratings) and by an independent assessor, not affiliated with this research. Whilst there were some small degrees of difference in the individual quality scores between assessors, all the papers were rated as being in the same category. The quality ratings ranged from 33% - 88% with an average rating of 75%. Studies were not excluded based on their quality assessment rating; however, ratings did inform the analysis and interpretation of the validity and reliability of the data.

Whilst the majority of studies included in this review were assessed as fairly high quality, there were some elements of the methodology that impacted on the quality of the studies but were not captured via the QATSDD. Predominantly, this was present in the mixed methods studies in which one aspect of the methodology was robust and methodologically sound, yet the other aspect lacked depth and detail in its execution. For example, the study conducted by Rees, Krabbe and Morgan (2009) reported quantitative data from 48 participants; however, only five participants contributed qualitative data, resulting in this data possibly not being generalizable to the rest of the participant sample. Similarly, in Bennett-Levy and Beedie (2007), the qualitative data was only captured if a certain score was reported on the quantitative measure, leading to possible data being missed or explored further.

Data extraction and synthesis

Due to the variation of methodologies and the diversity of outcome measures used, a statistical meta-synthesis could not be performed. Therefore, as recommended by the Centre for Reviews and Disseminations (2009), a narrative synthesis technique was employed to extract the main themes from the data, where the synthesis of findings relies primarily on the use of words to summarise and explain the findings of multiple studies. Themes were developed based on the relationships between the studies including their similarity of research question/aim and the context in which their findings were collected. A summary table of the studies reviewed was created which included their quality assessment rating (Table 1).

Table 1. Summary of papers included in the systematic review.

Authors, Year, Title and Country	Aims	Sample	Method/Analysis	Findings/Results	Quality Rating
Bennett-Levy and Beedie (2007). 'The Ups and Downs of Cognitive Therapy Training: What Happens to Trainees' Perception of their Competence During a Cognitive Therapy Training Course?', UK.	Explore the self-perception of competence in trainees during Cognitive therapy training.	24 trainees undertaking one-year Diploma in Cognitive therapy.	Completion of a self-rated assessment of competence at six time points during the course. If ratings changed between time points, participants completed a section on 'Beliefs regarding change in ratings over time'. Quantitative self-assessment scores were analysed using repeated measures analysis of variance. Qualitative responses were analysed using grounded theory methodology.	Quantitative data revealed that self-perception of competence increases significantly over time, however, this is different across different aspects of CBT. Qualitative data led to the development of a model to describe the numerous influences on the self-perception of competence during CBT training.	85% (high)
Bennett-Levy and Lee (2014). 'Self-Practice and Self-Reflection in Cognitive Behaviour Therapy Training: What Factors Influence Trainees' Engagement and Experience of Benefit?', Australia.	Explore what factors influence CBT trainees reported benefit of a component of CBT training – self-practice/self-reflection (SP/SR).	46 CBT trainees/practitioners from four different training programmes in CBT.	Qualitative data was analysed from written reflections of course participants, transcribed post-course individual and group interviews, post-course questionnaires and trainer observations. Data was analysed using grounded theory methodology.	Engagement and experience of benefit was shown to be central to the reported positive experiences of SP/SR. Other factors including course and structure requirements, expectation of benefit, feeling of safety with the process, group processes and available personal resources also were shown to influence the engagement and experience of benefit in SP/SR.	86% (high)

<p>Bennett-Levy, McManus, Westling and Fennell (2009). ‘Acquiring and Refining CBT Skills and Competencies: Which Training Methods are Perceived to be Most Effective?’, Sweden.</p>	<p>Explore what training or supervision methods CBT trainees perceive to be most effective for achieving CBT competencies during training.</p>	<p>120 CBT therapists attending a two-day workshop about becoming a better CBT therapist.</p>	<p>Participants completed the ‘Methods of Learning questionnaire’.</p>	<p>Different training methods were found to be effective for different types of knowledge: Declarative knowledge by reading, lectures/talks and modelling. Procedural skills by enactive learning strategies, modelling and reflective practice. Reflective capability and interpersonal skills by self-experiential work and reflective practice.</p>	<p>74% (moderate)</p>
<p>Bennett Levy et al. (2015). ‘Spontaneous Self-Practice of Cognitive Behavioural Therapy (CBT) by Aboriginal Counsellors During and Following CBT Training: A Retrospective Analysis of Facilitating Conditions and Impact’, Australia.</p>	<p>Explore the motivation, application and impact of counsellors who spontaneously utilised self-practice during and after their training.</p>	<p>Five Aboriginal counsellors undertaking 10 days of formal CBT training over 6-months.</p>	<p>Participatory action research design. Discussions focusing on the experience of practicing CBT in participant’s personal lives from two group meetings became the data, which was analysed using a thematic analysis.</p>	<p>Counsellors perceived CBT as personally and professional valuable and practiced it in a variety of contexts. Self-practice was also perceived to decrease burnout.</p>	<p>88% (high)</p>
<p>Chaddock, Thwaites, Bennett-Levy and Freeston (2014). ‘Understanding individual</p>	<p>Explore CBT trainees’ experiences of SP/SR as part of</p>	<p>Four trainees from a one-year CBT diploma course.</p>	<p>Quantitative data was gathered using several ratings on the Cognitive Therapist Self-Monitoring Scale (CTSMS)</p>	<p>Ratings of perceived competence suggested that individual differences were found in the response to SP/SR, relating to</p>	<p>81% (high)</p>

differences in response to Self-Practice and Self-Reflection (SP/SR) during CBT training', UK.	professional training in CBT.		providing self-ratings of competence across 12 aspects of CBT, and the Cognitive Therapy Empathy Scale (CTES). Qualitative data was gathered from written weekly reflections of SP/SR as well as an individual interview.	different ways that participants engaged with SP/SR materials.	
Foulkes (2003). 'Trainee perceptions of teaching of different psychotherapies', Australia and New Zealand.	Investigate the perceptions of senior psychiatric trainees regarding the extent and satisfaction of the teaching of five psychotherapies during psychiatric training (including CBT).	94 senior psychiatric trainees in Australia and New Zealand.	Questionnaires containing descriptive quantitative data and qualitative data were completed.	31% of trainees felt satisfied with the quality of CBT training and 90% felt there was not enough CBT training received.	33% (poor)
MacLiam (2015). 'Cognitive behavioural psychotherapy graduates in Ireland: a follow-up survey of graduates from	Explore the experience of CBT graduates, after their training and the	43 graduates from a University CBT course.	An online survey explored demographic information, past and present work, experience of the CBT course, clinical CBT supervision, continuous	The majority (55%) described their experience of the course as 'Excellent'. The course was perceived as enhancing one's career for 70% of respondents.	69% (moderate)

an Irish university', Ireland.	impact their training had upon them.		professional development (CPD) and general questions about the CBT course.		
Owen-Pugh (2010). 'The dilemmas of identity faced by psychodynamic counsellors training in cognitive behavioural therapy', UK.	Explore the dilemmas of qualified psychodynamic counsellors studying CBT.	12 qualified psychodynamic counsellors on a BA 'top-up' programme which included an introductory module in CBT.	Thematic analyses were carried out on participants learning journals as well as discussions from a focus group held 12 months after the module completion.	Initially participants struggled to say anything positive about CBT and were resistant to learning. Eventually, participants made deliberate attempts to engage with CBT and ultimately appraised it as an effective and ethical model of therapy.	76% (high)
Rakovshik and McManus (2013). 'An anatomy of CBT training: trainees' endorsements of elements, sources and modalities of learning during a postgraduate CBT training course', UK.	Explore which aspects are perceived as having the greatest impact on competence from trainees' evaluations of a postgraduate CBT training course.	73 students in their final month of a year-long Master's level CBT training course.	Paired <i>t</i> tests compared trainees' ratings for different elements of the training course from a 'course impact questionnaire'.	Supervision was perceived to have a greater impact on competence than clinical instruction. Interactions with trainers were given the highest rating as 'sources of learning', followed by learning by personal reflection, and then peer interactions.	81% (high)
Rees, Krabbe and Monaghan (2009). 'Education in cognitive-behavioural therapy for mental health professionals', Australia.	Evaluate a videoconferencing based CBT training programme.	48 participants who had completed the CBT training programme over a seven-year period.	Pre and post training, participants completed the Cognitive-Behavioural Therapy Knowledge Test (CBT-KT). Post training participants also completed the Videoconferencing Satisfaction Questionnaire (VSQ 7). Five	The majority stated they had enjoyed the course and would recommend it (95%), nearly all felt they had an increased understanding of CBT (97%) and that they had greater confidence in using CBT (96%).	52% (moderate)

			people also took part in a short group interview. Quantitative data was statistically and descriptively analysed and qualitative data was subject to a thematic analysis.	Qualitatively, participants stated that having an opportunity to receive supervised practice in CBT was the most useful aspect of the course.	
Schmidt and Foli-Andersen (2017). 'Psychotherapy and Cognitive Behavioural Therapy Supervision in Danish Psychiatry: Training the Next Generation of Psychiatrists', Denmark.	Investigate how psychiatrists in Denmark perceive and evaluate their psychotherapy training, and secondly to compare the quality of CBT supervision in psychiatric training with theoretical recommendations for good CBT supervision.	60 psychiatric trainees attending specialist training courses in Denmark. 36 had received CBT supervision and so participated in the second part of the study.	Questionnaires were distributed exploring the two study aims. Results were reported descriptively.	In relation to CBT supervision during training, the majority rated their supervisor favourably. Specific CBT supervision skills and methods were explored such as creating a collaborative agenda, summarising in session, and testing of theoretical CBT knowledge. These areas were rated as lower, highlighting the possibility that psychiatrists in training have little access to qualified CBT supervision.	73% (moderate)
Spafford and Haarhoff (2015). 'What Are the Conditions Needed to Facilitate Online Self-Reflection for Cognitive Behaviour	Explore the experience of utilising an online self-practice/self-reflection	Nine second year trainees from a postgraduate CBT programme.	Data from an online questionnaire and teleconference focus group was qualitatively analysed using a thematic analysis.	Feedback suggested that the online blog did help most participants facilitate self-reflective experience during CBT training. The main factors that impacted on the	76% (high)

Therapy Trainees?', Australia.	(SP/SR) blog to facilitate SP/SR during CBT training.			effectiveness of the blog were anonymity, structure, role of a facilitator, assessment, time and completion.	
Wolff and Auckenthaler (2014). 'Processes of Theoretical Orientation Development in CBT Trainees: What Internal Processes Do Psychotherapists in Training Undergo as They "Integrate"?', Germany.	Investigate the psychological mechanisms and processes of theoretical orientation development in psychotherapists during training.	20 psychotherapists in the final phase of their professional CBT training.	Individual problem-centred interviews, with data analysed using grounded theory methodology.	Trainees were characterised in the category of "constructing jugglers". To develop theoretical orientation during training trainees define and redefine CBT and other psychological approaches. Definitions of the self differed between defining oneself as a psychotherapist and defining oneself as a CBT therapist (where identifying with CBT is high and other approaches low, as well as emphasising the boundaries between CBT and other approaches). The other factor that influences the cycle of theoretical orientation during CBT training was CBT-friendly experiences during training. Theoretical orientation development consists of not only client outcomes or trainee skill development, but also identity and orientation development.	88% (high)

Results

Description of studies

Of the 13 studies included in the review, three utilised quantitative methodology, five utilised qualitative methodology and five utilised both quantitative and qualitative data. Studies were conducted in the UK ($n = 4$), Australia and New Zealand ($n = 5$), Ireland ($n = 1$), Sweden ($n = 1$), Germany ($n = 1$) and Denmark ($n = 1$). The focus of the reviewed studies appeared to fit within four themes; exploration of Self-practice/Self-reflection (SP/SR), internal processes throughout CBT training, perceived effective components of CBT training, and general satisfaction with CBT training. Each of these themes are discussed with reference to the data from the relevant reviewed studies.

1. The experience of Self-practice/Self-reflection (SP/SR)

Four of the reviewed studies (Bennett-Levy and Lee, 2014, Bennett-Levy et al., 2015, Chaddock, Thwaites, Bennett-Levy and Freeston, 2014, Spafford and Haarhoff, 2014) focused on one component of CBT training - Self-practice/Self-reflection (SP/SR).

Developed by Bennett-Levy et al. (2001), SP/SR is a structured, personal therapy-like programme that instructs cognitive-behavioural therapists to practice CBT techniques on themselves, then reflect and evaluate their experiences. The SP/SR programme has been formalised in to a CBT training paradigm, aimed at increasing CBT competence and skill via self-experiential experiences (Bennett-Levy and Lee, 2014).

All four studies were rated as 'high' quality, ranging from 76% - 88% and the majority utilised qualitative methodology. One study (Bennett-Levy and Lee, 2014) utilised a large sample size ($n = 46$), however, the remaining studies samples were comparatively small (ranging from $n = 4$ to $n = 9$).

The study conducted by Bennett-Levy and Lee (2014) aimed to develop a model that predicts the level of engagement and the experience of benefit in SP/SR by trainees in CBT. Participants were from four different training groups; two groups of postgraduate students on a clinical psychology program undertaking an introductory course in CBT, experienced psychologists undertaking a self-experiential training course in CBT and a group of mental health workers undertaking an introductory course in CBT. Demographic information such as age, backgrounds, experience and profession varied amongst the 46 participants.

Qualitative data was obtained from four sources; participants' written course reflections, transcribed post-course individual and group interviews, post-course questionnaires and trainer observations. Not all sources were utilised for each group. Data was analysed using grounded theory methodology and a detailed account of this process was provided. An empirically-driven model was developed, with 'Engagement' and 'Experience of Benefit' at the centre, in a reciprocating and repeating relationship. Five factors were found to influence engagement and experience of benefit; 'Course Structure and Requirements', 'Expectation of Benefit', 'Feeling of Safety with the Process', 'Available Personal Resources' and 'Group Processes'.

Strengths of this study included its detailed description of the research setting and varied sample, and its justification and descriptive account of the data analysis. Whilst data was collected from four different sample groups, the method of data collection varied, resulting in less comprehensive contributions from some of the groups of participants.

Employing a single-case design, Chaddock et al. (2014) examined the experiences of four CBT trainees undertaking SP/SR as part of their training. This study provided both quantitative and qualitative data via self-ratings of skill and written reflections following the completion of SP/SR and linked its findings clearly to an explicit theoretical framework (the DPR model of therapist skill development, Bennett-Levy, 2006). An explanation for the

choice of measurement tool however, was not provided and little justification was given for the analytical method adopted in this study. The findings reported that engagement differs based on individual differences including the preference to engage in different modalities of the self during SP/SR; some participants favoured ‘personal self’, some ‘therapist self’, and others ‘trainee self’. The greatest perceived benefit of SP/SR was found when the trainee engaged both ‘personal self’ and ‘therapist self’ during SP/SR, and the least beneficial stance of participating in SP/SR appeared to be if the ‘trainee self’ was the dominant focus. Overall whilst the study provided an interesting insight into the experience of SP/SR, the small sample size means these findings may not generalise to the wider context of CBT training.

Spafford and Haarhoff (2015) explored the utilisation of an online blog to help facilitate the engagement of SP/SR within a CBT training program. Nine participants provided qualitative data from a feedback questionnaire and a teleconference focus group, and data was analysed using thematic analysis. Whilst the method of data collection and analysis were adequate, conclusions may have benefitted from more detailed accounts of individuals’ experiences of this component of CBT training, as well as involving previous students in the development of the feedback questionnaire. Findings suggested the online blog enhanced most trainees’ experience of the self-reflective component of SP/SR. However, the authors concluded that factors such as anonymity, the role of a facilitator, assessment, and time and completion should be considered when contemplating the effectiveness of such a blog.

In the final study exploring SP/SR, Bennett-Levy et al. (2015) explored students undertaking a ten-day, formal training program where SP/SR was not recommended or explicitly encouraged. The researchers employed a ‘participatory action research’ approach to explore trainees’ reports of spontaneous engagement in self-practice during and after training and therefore, heavily included participants in the study’s design – a component that many of

the studies in this review lacked. Five participants provided qualitative data from two group meetings where this topic was discussed was analysed using thematic analysis. Findings reported that participants were motivated to practice CBT on themselves because of their training and due to the value they placed on the therapeutic model and for their own personal need. Participants reported that self-practice also increased their confidence and competence as CBT therapists and suggested that it also serves as a useful burnout prevention strategy. Results should be interpreted with caution from this study, mainly due to its small sample size and lack of detail within the data collection and analysis.

Summary

The four studies exploring SP/SR within this review concluded that it is a helpful component of CBT training, which, if engaged in, is often experienced positively. New and innovative ways of utilising technology are emerging in the field of SP/SR to identify ways of enhancing its benefit during CBT training. The reported benefits of SP/SR appear to extend beyond the boundaries of professional training and experience in CBT, into personal contexts and situations.

2. Internal processes throughout CBT training

Three of the reviewed studies (Bennett-Levy and Beedie, 2007, Owen-Pugh, 2010, Wolff and Auckenthaler, 2014) explored the internal processes that trainees experience during CBT training. All three studies were rated as 'high' quality, ranging from 76% - 88%. One component that was absent from all three studies was the involvement of users in the study design.

Bennett-Levy and Beedie (2007) explored the self-rated assessment of competence from 24 trainees undertaking a one-year CBT training program. Trainees completed the 'Cognitive Therapy Self-Rating Scale' (CTSS) on six occasions throughout training. Whilst the CTSS

was a modified, self-assessment version of the CTS, it had not been tested for reliability and validity. The study attempted to overcome this by establishing statistical consistency with supervisors' ratings of competence, however, formal statistical assessment of the CTSS was not available. Within the study, if scores had increased by two points or more, or decreased by one point or more, participants completed a section headed "Beliefs regarding change in ratings over time" to provide a qualitative description of reported changes. A detailed explanation and rationale for choosing the "increase" and "decrease" change ratings at two points was provided. Quantitative data was analysed (using a *t* test and repeated measures analysis of variance, paired with post hoc tests) and a statistically significant increase in the self-ratings of competence was shown between the 1st and 6th ratings of the CTSS.

Qualitative responses regarding the changes in ratings were analysed using grounded theory methodology to develop a model incorporating the influence of learning opportunities, cognitive impact and emotional state on self-perception of competence. Overall, the study provided a good fit between the research question and its method of data collection and analysis.

Owen-Pugh (2010) conducted a qualitative study of 12 qualified psychodynamic counsellors studying a University module that included an introductory course in CBT. A thematic analysis on participants learning journals and the transcripts from a focus group held a year after the module completion was undertaken. Whilst the researcher's position and approach to the data analysis was stated, the study failed to report on any formal assessment of reliability of the analysis, such as reviewing the data and subsequent themes with someone independent from the research. Additionally, alternative data collection methods (such as individual interviews) and subsequent analysis could have provided greater detail. Results found that initially participants struggled with anxieties and the differences between CBT and their core theory of psychodynamic therapy, which produced resistance to learning.

Eventually, as the module progressed, participants made deliberate attempts to engage with CBT and its techniques, and ultimately appraised the new model as effective and ethical. Whilst the study did explore the experience of CBT training, it described its findings with a focus on the transition from one psychological model to another.

Wolff and Auckenthaler (2014) focused on the internal process of theoretical orientation development that 20 German psychotherapists experienced during the last phase of their professional training in CBT. Although some demographic information was provided about participants, limited information was reported on the process of recruitment. Individual, problem-centred interviews were conducted and qualitative data was coded and analysed using grounded theory methodology. The study provided a detailed account of the theoretical framework and the method of data collection and analysis allowed for a degree of depth to be explored within the topic of interest. Results found that the processes involved in developing theoretical orientation are complex, constantly changing and serve a psychological function for trainees. Most dominant within this complex journey was the process of constantly defining and redefining CBT and other approaches, utilising strategies such as ‘blurring boundaries’ between CBT and other approaches if they experienced a positive encounter with another therapeutic approach, and ‘emphasising the boundaries’ between approaches if a negative experience was encountered. The study reported that trainees are actively involved in the development of their own theoretical orientation during CBT training and that it is not simply a result of client outcomes or trainees’ skill development, but also includes identity and orientation development. Methodological considerations focused only on the sample, and other strengths and limitations such as commenting on the procedure and data analysis were not explicitly reported.

Summary

Overall, the studies reviewed that focused on the internal processes that occur during CBT training show that trainees may experience difficulties throughout training regarding their self-perception of competence and professional identity, but eventually, once training is complete, these difficulties will often resolve and training is perceived as a positive experience.

3. Perceived effective components of CBT training

Two studies focused on CBT trainees' experience in the context of evaluating which components of training programs are effective. One study (Bennett-Levy, McManus, Westling and Fennell, 2009) was rated as 'moderate' quality (74%), and the second (Rakovshik and McManus, 2013) was rated as 'high' quality (81%). A noticeable strength of these two studies was their large sample size ($n = 120$ in Bennett-Levy et al., 2009 and $n = 73$ in Rakovshik and McManus, 2013). Both studies collected quantitative data and both appeared to omit user involvement within the study design.

Bennett-Levy et al. (2009) conducted a study on 120 CBT therapists attending a workshop to improve their practice. A detailed account of the varied sample was provided. Participants completed the 'Method of Learning Therapy Skills Questionnaire' and were asked to identify the most effective learning methods for 11 items of therapist knowledge/skills. There was no statistical assessment of the validity and reliability of this measure, and an 'eyeball' analysis was performed as opposed to a formal statistical analysis. Results were interpreted within the context of an explicit theoretical framework – the DPR model of therapist skill development (Bennett-Levy, 2006). Reading and lectures/talks were rated as most effective for learning declarative and conceptual knowledge; modelling was highly rated for declarative and procedural skills; role-play was rated as most effective for procedural learning and reflective

practice and self-experiential work was rated as most effective for reflective and procedural learning systems.

In the second study focusing on trainees' experiences of the effective elements of CBT training, Rakovshik and McManus (2013) reported the results from a course evaluation of a one-year, Master's-level CBT training course from three cohorts ($n = 73$). Despite a lack of an explicit theoretical framework, specific to this research question and findings, the study provided clear and detailed descriptions of recruitment, data collection and analysis. The course evaluation measure however, did not appear to be statistically assessed for validity and reliability. Results from paired t tests revealed significant differences between the endorsements of the impact of various aspects of learning. Supervision was perceived to have more influence on competence than clinical instruction, with interactions with trainers given the highest rating. There was a relatively low rating of peer-related learning, suggesting that is not an essential criterion for effective training.

Summary

In conclusion, these studies suggest that trainees perceive differences in the components of CBT training when assessing their influence on competence. Trainees' appear to experience interaction with supervisors and facilitators during training as valuable and effective.

4. General satisfaction with training

Four studies focused on general satisfaction with CBT training, using feedback questionnaires. These studies varied in their quality ranging from 'low' quality (33%, Foulkes, 2003) to 'moderate' quality (73%, Schmidt and Foli-Andersen, 2017). None of the studies described an explicit theoretical framework for which the constructs were applied to the research, however, due to the survey methodology, sample sizes used in these studies were relatively larger than others included in this review.

Foulkes (2003) surveyed the satisfaction of 94 psychiatric trainees focusing on the quality and quantity of their psychotherapy training using quantitative and qualitative data. Before formal data collection was carried out, a pilot study was conducted; however, it was not clear whether any changes to the design were made following this. The survey explored five different modalities of therapy, however, responses related only to CBT were focused on for this review. Only 31% of trainees felt satisfied with the quality of CBT training they received and 90% reported there was not enough time spent on CBT training. Whilst this study provided some basic information into these trainees' experiences of CBT training, the results should be interpreted with caution. This study was rated as 'poor' quality given its lack of detail across many aspects of the study's design. It is noted that the CBT training explored in this study is not a stand-alone, CBT course, but rather a component of general psychiatric training. This may explain the dissatisfaction with the quantity of CBT training received.

Focusing on specific CBT training, MacLiam (2015) conducted an internet based survey with 43 graduates from a University based CBT training course, primarily focusing on graduates' learning, development and experience after the course. The survey also enquired into graduates' retrospective experiences of the CBT course using quantitative and qualitative responses. A detailed description of the study's recruitment, sample and data collection method were provided. Quantitative findings were reported in a descriptive manner, such as the majority (55%) of participants described their experience as 'Excellent' and no ratings were received for negative options. Limited qualitative findings were provided such as participants comments regarding the positive experience of the reflective aspect of the course and general complimentary comments were made about the teaching, organisation and value of CBT. Conclusions and implications for training courses may have benefitted from a more detailed presentation of the qualitative responses to enhance the understanding of training experience further.

Exploring the use of technology in training, Rees, Krabbe and Monaghan (2009) conducted a study exploring experience of CBT training via videoconferencing and measuring knowledge after this training. Quantitative data was obtained from the 'Cognitive-Behavioural Therapy Knowledge Test' (CBT-KT) and the 'Videoconferencing Satisfaction Questionnaire' (VSQ 7). Qualitative responses were obtained from a short group interview post-training, which were analysed using thematic analysis. Results described a positive experience of the training, with increased confidence and understanding in CBT being reported. Qualitatively, trainees reported supervised practice as the most useful aspect of the course. Similarly to the other studies within this section, detail was lacking in some elements of this studies' design, and results should be interpreted with caution, as the research question focused on assessing the perception of CBT training via videoconferencing methods, as opposed to solely the experience of CBT training.

The final study was conducted by Schmidt and Foli-Andersen (2017). Focusing on psychiatric trainees, a survey in two parts was completed by 60 participants exploring their evaluations of the psychotherapy training, and (of interest in this review), their perceptions of the quality of CBT supervision they received during their training. As not all had experienced CBT supervision as part of their training, only 36 participants completed the second part of the survey relating to CBT. All results in this study were quantitative, and further detail could have been obtained from supporting qualitative responses. Findings revealed that whilst trainees rated their CBT supervisors positively, specific CBT skills and supervision methods (such as summarising in session and creating a collaborative agenda) appeared to be lacking, suggesting that in Denmark, good quality CBT supervision is of limited availability during psychiatrists' psychotherapy training. It is not known whether these findings can be generalised to the other psychiatry training programmes in other countries. Similarly, to the study conducted by Foulkes (2003), these interpretations should be interpreted with caution

as the CBT training experience is taken from a wider, psychiatric training program containing many different components.

Summary

Overall, the findings from these studies appear mixed. Two report positive experiences of CBT training, and two report the need for greater quality and quantity of training received. It should be noted that the two studies reporting a more negative view of training explored CBT teaching as part of psychiatric training, and so should be interpreted with caution. Whilst this survey-type research provides a clear picture of the overall satisfaction with CBT training explored, responses tended to be phrased in evaluative terms, rather than descriptive, so the depth of trainees' experience may be missed.

Discussion

This review explores the experience of CBT training. Some conclusions can be drawn including trainees' positive experience of specific elements of CBT training (namely, SP/SR and interactive components such as supervision), and changes in trainees' self-perception of their own competency and their experience of theoretical orientation throughout their training. General satisfaction from specific CBT training courses appear to be positive, however, further detail and cross-course exploration would provide a broader understanding. Training in CBT that is undertaken as part of general psychiatric training appears to be lacking in quality and quantity and more detailed research should explore this further.

The findings from this review appear to fit with previously published research. Many of the studies reviewed provided empirical evidence to supportive the DPR model (Bennett-Levy, 2006) of therapist skill acquisition and refinement. Some suggested that supervision and facilitator interaction is perceived by trainees as having the greatest impact on their

competence during CBT training. These are consistent with the conclusions from the systematic review by Muse and McManus (2013), that supervisory ratings of ‘in-session’ clinical performance provide a robust method for assessing competence, and with the findings by Beidas et al. (2012) that active learning is trainees’ preferred modality of training.

Strengths and limitations of the review

Overall, the studies included in this review used a variety of designs, outcome measures and analyses, in different research settings. A broad amount of data has been included in this review and it is possible that its breadth may have led to some studies being included which are arguably of limited relevance to this topic (namely the studies exploring CBT training as part of psychiatry training). This review highlights a lack of literature surrounding the experience of CBT training and future studies should continue to explore different methodologies to enhance our understanding of this in a scientific manner.

Due to the variation in these reviewed studies, generalising the findings to the wider population of CBT training should be approached with caution. Further research needs to be conducted on the experience of CBT training in specific courses across different countries to develop more stable conclusions.

It can be assumed that if future research continues to explore the experience of CBT training, courses can improve their standards, whilst incorporating new and innovative ways to deliver effective training that students find beneficial.

Implications

The implications of this review are relevant to students, course providers and training commissioners. Firstly, students undertaking CBT training should be encouraged to acknowledge the internal processes that occur, namely, the change in their self-perception of

competence, and the journey of acquiring their theoretical orientation and definition. Also, for students to be aware that engagement has been shown to be central to benefitting from some aspects of CBT (namely, SP/SR).

Training course providers should acknowledge these findings and incorporate the ‘student voice’ into course structures and developments. Components that are perceived by students to have an impact on their competence should be encouraged, and other aspects perceived as less effective should be reviewed.

At a strategic level, commissioners should incorporate the findings of this systematic review into their planning and commissioning of CBT training courses to ensure that students are not only achieving the recognised level of skill and competence development as dictated by course providers, but also that students’ personal reflective abilities and perception of competencies are addressed.

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Ethical statements

Not applicable.

Conflicts of interest

None.

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Paper 2: The Empirical Study

Exploring Cognitive Behavioural Therapy Diploma Students' Construal of their Personal and Professional Development

Manuscript prepared in accordance with the guidance for the
Clinical Psychology and Psychotherapy Journal (see Appendix 4[†])

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Abstract

This study employed Personal Construct Theory (Kelly, 1955) and the repertory grid technique (Fransella, Bell & Bannister, 2004; Jankowicz, 2004) to explore the experience of students conducting a Diploma-level training course in Cognitive Behavioural Therapy (CBT). Eight students were interviewed pre and post training. Bipolar constructs related to CBT training were created using 11 elements. The elements were then ranked on each bipolar construct to create a repertory grid. Participants construed themselves as closer to ‘desirable’ elements such as an ‘Ideal therapist’, ‘Ideal self’ and ‘Compassionate therapist’ post training. Paired sample t-tests revealed there was a significant shift in the perceptions of an ‘Ideal therapist’ post training along with an increase in ‘Intellectual/Operational’ constructs. The discussion suggests staff capability, attitudes and values improved in line with the ambitions of Welsh Government strategy and makes recommendations to improve students’ experience during CBT training.

Key Practitioner Message:

- Students’ construal of what an ‘Ideal therapist’ changes throughout Diploma-level training in Cognitive Behavioural Therapy.
- ‘Intellectual/Operational’ constructs are more dominant for students after their training in Cognitive Behavioural Therapy when construing elements related to their personal and professional development.
- Training in Cognitive Behavioural Therapy should provide regular feedback on students’ progress and encourage personal and professional development throughout the journey training, including preparation for accreditation.

Keywords: cognitive behavioural therapy training, experience of training, personal development, professional development, personal construct theory, repertory grids.

Introduction

There is a growing body of evidence that Cognitive Behavioural Therapy (CBT) is an effective psychological therapy for various mental health difficulties (National Institute of Clinical Excellence, NICE, 2004a, 2004b, 2005). CBT is often the treatment of choice recommended in the strategic planning of the delivery of psychological therapies across the United Kingdom (UK). The ‘Increasing Access to Psychological Therapies’ (IAPT, Clark *et al.*, 2009) initiative in England aims to increase access to a range of evidence-based psychological therapies, by providing funding to redesign services and develop the workforce to deliver interventions. Within IAPT, CBT accounts for the largest number of ‘high intensity’ practitioners due to its broad evidence base and dominance within the NICE guidance (Liness, Lea, Nestler, Parker & Clark, 2017).

In Scotland, ‘The Matrix’ (National Health Service Education for Scotland, NES, 2011, 2015) provides the local National Health Service (NHS) boards in Scotland with a guide to the planning and delivery of psychological therapies. ‘The Matrix’ outlines a summary of the evidence-based interventions for specific mental health difficulties and the level of training required to deliver such interventions.

Similarly, in Wales, the ‘Matrics Cymru’ highlights the evidence base for different mental health disorders and outlines a stepped care approach to the delivery of psychological therapies (National Psychological Therapies Management Group & Public Health Wales, 2016). The ‘Matrics Cymru’ clearly states that individuals who experience moderate-severe mental health problems should have access to a ‘high intensity specialist’ intervention, delivered by practitioners who have achieved Diploma-level training. Both the Scottish ‘Matrix’ and the ‘Matrics Cymru’ frequently recommend CBT as the evidence-based treatment for numerous psychological difficulties.

The above factors have led to a need for effective training courses in CBT to be developed and delivered across the UK. Few studies have focused solely on CBT training, with data and findings related to training sometimes regarded as simply a ‘by-product’ of efficacy and effectiveness studies of CBT (Rakovshik & McManus, 2010). Clear research exploring all aspects of CBT training programmes could be of great value to commissioners and service planners aiming to increase access to evidence-based psychological therapies.

In 2010, a Diploma-level training course in CBT, accredited by the British Association for Behavioural & Cognitive Psychotherapies (BABCP), was evaluated (McManus Westbrook, Vazquez-Montes, Fennell & Kennerley, 2010) in Oxford, England. Results from a large sample ($N = 278$) found that Diploma-level training was associated with an increase in ratings of clinical skills, as assessed by using the Cognitive Therapy Scale (CTS, Young & Beck, 1980, 1988) and other objective measures such as scores on academic assignments. This suggested that accredited Diploma-level training leads to increased competence in CBT, which is significant because therapist competence has been shown to improve patient outcomes in CBT (Trepka, Rees, Shapiro, Hardy & Barkham, 2004).

Exploring students’ experience of CBT training, Bennett-Levy and Beedie (2007) found that there is a significant increase in students’ self-perception of their competence during a one-year Diploma-level CBT training course, particularly in the ‘structural’ aspects of CBT (such as interview skills) and in technical interventions (CBT specific techniques). Students also reported smaller, but statistically significant, increases in interpersonal effectiveness. Bennett-Levy and Beedie (2007) synthesised these findings to develop a model illustrating the ‘Influences on Self-Perception of Competence’ (Figure 1) using grounded theory analysis.

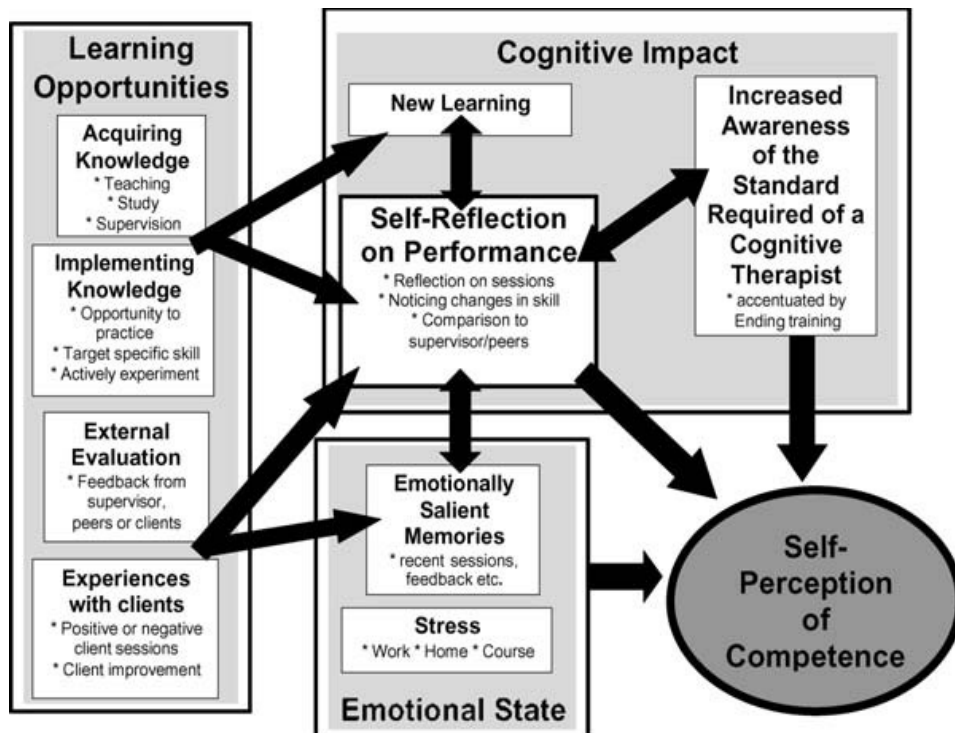


Figure 1. Model of the influences on self-perception of competence (Bennett-Levy & Beedie, 2007).

The model describes three components that influence the self-perception of competence; learning opportunities, their cognitive impact and the student's emotional state. Bennett-Levy and Beedie (2007) highlight that both trainees and supervisors may benefit from understanding this model to help normalize fluctuations in self-confidence during CBT training.

Niemi and Tiuraniemi (2010) explored Finnish students' perceptions of the important aspects of a four-year training course in CBT and their impact on students' self-assessment of competence. The training course in Finland consists of extensive theoretical practice (400 hours), clinical practice (300 hours) and supervision (140-180 hours). Using self-report and self-rating measures, the study found that students reported the most significant progress in their practice of cognitive and constructivist strategies, with the focus being on technical and

conceptual skills and knowledge. Interpersonal skills appeared to be peripheral in students' self-reflections of training.

Rakovshik and McManus (2013) explored which aspects of a Diploma-level CBT course students felt had the greatest effect on their competence. Supervision was perceived to have a greater influence on competence as opposed to instruction; lending support to the requirement for all BABCP accredited programmes to include clinical supervision by an accredited CBT practitioner (BABCP, 2017).

Although the BABCP suggest personal development should be recognised during CBT training (McDonald & Haddock, 2012) and ongoing attention should be given to professional development beyond training (BABCP, 2016), research thus far has addressed trainees' perceptions of what helps develop their skill and competence in CBT training (Jenkins, 2017). Research has not explicitly explored the experience of CBT training in terms of individuals' wider personal and professional development. Whilst the growing body of evidence and policies recommends CBT as an evidence-based practice for psychological difficulties, the need to understand CBT training is arguably, of great importance. In healthcare contexts in Wales, where resources are limited and there is an increasing need for highly skilled, compassionate staff (Welsh Assembly Government, 2012), little is known about the impact of CBT training on staff's self-perceptions of themselves in a personal and professional context.

The broader literature on psychotherapy training has explored psychotherapists' perceptions of what components influence their development. Orlinsky, Botermans & Rønnestad (2001) administered a length survey called the 'Development of Psychotherapists Common Core Questionnaire' asking 4,923 psychotherapists from around the world, what has contributed to their development. Results found that the most important positive influences were practice-related interpersonal situations (i.e. working directly with clients), formal

supervision and the therapist's own personal therapy. These findings relate to some aspects of the literature on CBT training, namely, that supervision is perceived as an important factor in development and training. It should be noted however, that the data collected as part of this study was structured in the area of 'career development' rather than specific to development as a result of training.

In 2013, Pieterse, Lee, Ritmeester and Collins described that research on process of self-awareness development among counselling and psychotherapy trainees was lacking in the literature. The authors present an integrated model that allows for self-awareness during training to be made more explicit. The model outlines the vast range of factors that impact on the individual including, but not limited to relational style, personality traits and social class. This model does not appear to have been applied yet in CBT training, and the researchers state that further research should be conducted on psychotherapy trainees, focusing on their personal and professional development.

The constructivist approach of Personal Construct Theory (PCT, Kelly, 1955) is one theory that has the potential to inform the exploration of a student's personal and professional development during CBT training. PCT describes the dynamic process of individuals forming and revising their construction of themselves and the world through their experiences. Kelly described that humans use bipolar constructs (e.g. 'happy-sad', 'reliable-careless' and 'funny-dull') to base their behaviour on and make predictions about the world. These constructs form a hierarchical personal construct system that changes based on feedback that an individual receives from their experiences. PCT has been utilised as both a psychological intervention (Neimeyer & Baldwin, 2003) as well as a way of exploring human constructs within research; for example, exploring staff construal of inpatients with eating disorders (Woodrow, Fox & Hare 2010) and examining trainee Clinical Psychologists' construal of their personal and professional development (Hill, Wittkowski, Hodgkinson, Bell & Hare,

2015).

The repertory grid technique is a methodology for measuring personal constructs (Fransella, Bell & Bannister, 2004; Jankowicz, 2004). This technique describes the ‘bipolar’ constructs of PCT as extremes of a continuum that can be elicited by asking about the similarities and differences between interesting ‘elements’. The data that is produced from this method is the repertory grid, which can be analysed using both quantitative and qualitative methods, at an individual and group level.

Aim of this study

This study aimed to explore how Diploma-level students on a CBT course construed their personal and professional selves, both before and after their training, using PCT and the repertory grid technique. As an exploratory study, no hypotheses were tested or proposed ahead of the data collection.

Method

Study design

This study was a within-subjects, repeated measures design. Participants from a postgraduate Diploma in CBT course were interviewed at two time points; pre and post training.

The training course

Participants were recruited from the 2016 intake of the postgraduate Diploma in CBT course based at Cardiff University. * Aimed at practicing, qualified mental health professionals,

* At the time of writing, this was the only course in Wales accredited by the BABCP. Whilst in England, places on such training courses are funded by the government, in Wales, this was not the case. Individuals who enrol on the course either self-fund or have local agreements

students complete a postgraduate Certificate in CBT as the first year of their training. The second, postgraduate Diploma year of the training programme consists of 14 supervision sessions delivered by accredited practitioners. Assessment takes place in the form two logbooks, a record of CBT practice and CBT supervision (of which 10 out of 14 sessions must be attended) clinical sessions rated by supervisors on the Cognitive Therapy Scale – Revised (CTS-R, Blackburn, James, Milne, & Reichelt, 2001) and a meta-competence case report.

Participants

The sample consisted of eight participants ($N = 8$) out of a potential ten, all of whom were female. The inclusion criterion was being a member of the postgraduate Diploma course cohort of 2016. One member of the cohort was excluded as they were clinically supervising the lead researcher (HJ) at the point of data collection.

The participants' mean age was 43.9 years (standard deviation [SD] = 11.5, range = 29-65). The majority of participants were mental health nurses ($n = 6$); one was an assistant psychologist, and the other a psychological wellbeing practitioner. This study was granted ethical approval from Cardiff University School of Psychology Ethics Committee (Reference: EC.15.12.08.4403R2A, see Appendix 5).

Designing the repertory grids

The repertory grid consisted of 11 elements identified by the authors of this study which included staff (LW, CBT Programme Lead, DJH, knowledgeable and experienced in the repertory grid technique) and students (NT, a Clinical Psychologist undertaking the

with their employers, primarily the NHS Local Health Boards. The programme also accepts applicants from outside of Wales.

postgraduate Diploma in CBT and HJ, a trainee Clinical Psychologist). Elements were chosen to reflect stages of personal and professional development, before, during and after the course, including elements aimed to facilitate comparison to other professionals and colleagues (Table 1).

Table 1. Elements.

Element 1	Self before training (postgraduate Certificate in CBT)
Element 2	Actual self (current)
Element 3	Self after training (postgraduate Diploma in CBT)
Element 4	Ideal self
Element 5	Someone doing the same job who doesn't have CBT training
Element 6	An ideal therapist
Element 7	A compassionate therapist
Element 8	A compassionate person
Element 9	Someone you would turn to for help
Element 10	Someone who is helpful in your team
Element 11	A skilful therapist / a skilled helper

Procedure

An explanation of the study and the 'Participant Information Sheet' (Appendix 6) was given to all potential participants during the course induction. Those who were willing to participate signed a consent form (Appendix 7) and provided their email address to arrange the first interview. The first set of interviews were conducted before the course begun (between January and February 2016) and the second set, once the course was complete and

results were given (between October and December 2016). At the beginning of the first interview, participants completed a brief demographic form (Appendix 8).

Based on the interview procedure outlined by Jankowicz (2004), constructs were elicited using the triadic difference method. All elements were printed on separate cards, and three were selected at random. Participants were asked to consider how two of the selected elements were similar and different from the third. This similarity then formed the emergent pole of the bipolar construct; the implicit pole of the construct was formed by asking the participant what the opposite of the emergent pole was. Participants then had to rank each of the elements on this construct where '1' represented a rating closer to the emergent pole, and '11' represented a rating closer to the implicit pole. This process was repeated until no new constructs were created.

On average, interviews lasted approximately 60 minutes (range = 45 - 90 minutes). All interviews were audio recorded to allow the interviewer to focus on the process of the interview with assurance that any spontaneous commentary could be listened to after the interview. All interviews were conducted independently at either Cardiff University or at the participants' place of work. All interviews were confidential and an identification number as opposed to their names identified participants throughout the research. Once data collection was complete, participants were sent a debrief form (see Appendix 9).

Data analysis

Element pairs of interest were identified to analyse any differences in the participants' construal of themselves in relation to 'desirable' elements; 'Ideal self', 'Ideal therapist', 'A compassionate therapist' and 'A skilled therapist/helper'. Grid data was inputted into 'Idiogrid' software (Grice, 2002), where the Euclidean distances between elements could be computed. Euclidean distance measures the extent to which an individual perceives two

elements as similar (Winter, 1992). Further analyses were conducted using IBM SPSS Statistics v20.0 (IBM Corp, 2011).

To undertake further analyses of the construct data, all constructs were categorised into eight categories using the Classification System for Personal Constructs (CSPC, Feixas, Geldschläger & Neimeyer, 2002). There were 166 constructs created by participants across the two time point interviews, between the participants, however, 164 were categorised, as two were duplicates. All constructs were independently rated with two iterations, which yielded 90.4% agreement (148/164 constructs). This level of agreement was deemed acceptable as outlined by Jankowicz (2004).

Results

To explore the direction and degree of change during CBT training, the Euclidean distance between each of the 'desirable' elements and 'Actual self', 'Self before training' and 'Self after training' was computed (see Table 2 for results).

Table 2. Mean Euclidean distances for element pairs.

'Desirable' elements	Pre training mean	Post training mean	Time point when smallest Euclidean distance observed
Actual self			
Ideal self	10.16	10.02	Post
Ideal therapist	12.32	12.25	Post
Compassionate therapist	12.94	11.76	Post
Skilled therapist/helper	11.85	12.15	Pre
Self before training			
Ideal self	14.57	16.74	Pre
Ideal therapist	15.79	18.26	Pre
Compassionate therapist	12.88	10.31	Post
Skilled therapist/helper	13.34	14.31	Pre
Self after training			
Ideal self	9.38	10.69	Pre
Ideal therapist	10.49	12.11	Pre
Compassionate therapist	13.93	11.50	Post
Skilled therapist/helper	11.09	10.87	Post

To explore change in the participants' construal of the individual elements, t-tests were performed on the mean rankings of all the elements pre and post training. A significant result was observed in the ranking of the 'Ideal therapist' pre training ($M = 2.88$, $SD = 1.28$) and

post training ($M = 3.94$, $SD = .47$) conditions; $t(7) = -2.76$, $p = < 0.05$. The effect size for this analysis ($d = -1.10$) was found to exceed Cohen's (1988) convention for a large effect ($d = 0.80$).

Constructs were analysed using the CSPC (Feixas *et al.*, 2002, see Appendix 10 for description). The CSPC categories have been shown to have a high level of interrater reliability ($\kappa = 0.947$, Feixas *et al.*, 2002). Examples of the types of constructs created in this study within each category are shown in Table 3 and the numbers and percentages of constructs from each category are shown in Table 4.

Table 3. Examples of constructs created for each category from the Classification System for Personal Constructs (Feixas *et al.*, 2002).

Construct category	Examples
Moral	<ul style="list-style-type: none"> • Helpful – Disinterested • Compassionate – Uncaring • Non-judgemental - Judgemental
Emotional	<ul style="list-style-type: none"> • Kind – Cruel • Calm – Highly strung/Anxious • Content – Miserable
Relational	<ul style="list-style-type: none"> • Supportive – Disruptive • Approachable – Unapproachable • Person-centred – Directive
Personal	<ul style="list-style-type: none"> • Confident – Unconfident • Willing to learn – Unwilling to learn • Motivated – Stagnant
Intellectual/Operational	<ul style="list-style-type: none"> • Competent – Incompetent • Experienced – Inexperienced • Accredited - Unqualified
Existential	<ul style="list-style-type: none"> • Eager to develop/improve self – In-congruent • Determination to do better – No desire for self-development • Leader to learning – Institutionalised

Table 4. Constructs categorised using the Classification System for Personal Constructs

(Feixas *et al.*, 2002).

Overall (total = 166)					
Construct category	Number			Percentage	
Moral	22			13.25%	
Emotional	15			9.04%	
Relational	34			20.48%	
Personal	33			19.88%	
Intellectual/ Operational	56			33.73%	
Existential	6			3.61%	
Pre training (total = 86)			Post training (total = 80)		
Construct category	Number	Percentage	Construct category	Number	Percentage
Moral	14	16.28%	Moral	8	10%
Emotional	9	10.47%	Emotional	6	7.5%
Relational	20	23.26%	Relational	14	17.5%
Personal	15	17.44%	Personal	18	22.5%
Intellectual/Operational	24	27.91%	Intellectual/Operational	32	40%
Existential	4	4.65%	Existential	2	2.5%

In the post training interviews, participants created constructs that fell mostly within the ‘Intellectual/Operational’ category. This contrasts with the pre training interviews, when there was a more equal split between ‘Relational’ and ‘Intellectual/Operational’ constructs.

There was a slight increase observed in the number of constructs created in the ‘Personal’ category in the post training interviews.

Discussion

Summary and interpretation of results

Participants construed themselves as closer to most of the ‘desirable’ elements post training. Further analysis shed light on this by revealing that participants’ construal of the ‘Ideal therapist’ was significantly different post training. Participant’s view of an ‘Ideal therapist’ changed from before training to after training, representing a ‘moving of the goal posts’. This phenomenon needs to be recognised as an inherent part of the methodology and the dynamic nature of constructs in repertory grids are flexible and highly sensitive (Jankowicz, 2004).

The metric of Euclidean distance is taken as an index of psychological similarity (Leach, Freshwater, Alridge & Sunderland, 2001). Students in this study did not rank themselves as closer to all of the ‘desirable’ elements post training, indicating their awareness of their need for further development. This is consistent with the level of BABCP accreditation of the programme at Level One, indicating a high quality training course, but with a need for further elements to be completed, in order to achieve full practitioner accreditation. Therefore, the Euclidean distances observed in this study may represent students’ progression rather than their perception of absolute change as a result of Diploma-level training in CBT.

In the construct category analysis, participants created more ‘Intellectual/Operational’ constructs post training, which suggests training, stimulated their intellectual development. Given the literature regarding the learning cycle and stages of competence (Conscious Competence Learning Model, n.d.) findings in this study may reflect participants transitioning from ‘unconscious incompetence’ to ‘conscious incompetence’. These results

suggest that CBT trainees are reflective in their practice and in their perception of their own competence. It is currently unknown whether those who go on to achieve full practitioner accreditation construe themselves in the latter two stages of the competence model.

Overall, the results from this study suggest that whilst CBT training provides individuals with an increase in skills and competence, it has the potential to leave individuals with an increased perception of their own incompetence. This supports the need for individuals to further their competence within the framework of regular, supervised practice, as recommended by the BABCP.

During and after their Diploma-level training, participants in this study may have been more aware of the requirements for full BABCP practitioner accreditation in CBT, leading them to feel further away from becoming their 'Ideal therapist' as they were conscious of the further development required.

Many participants voluntarily disclosed during the interviews that they had expected to obtain grades higher than a 'pass'. Other courses within the UK provide the same accredited training, but with a greater time commitment. For example, the University of Oxford use a training format run across 36 days, comprising of 90-minute group supervision followed by a five hour workshop to enhance clinical skills (Rakovshik & McManus, 2013). It is possible that participants interviewed for this study were not aware that they were being assessed at the same standard as trainees on longer, more intensive training courses. Training programmes accredited by the BABCP at Level One and Level Two differ in the quantity but not the quality of training, with trainees on Level One programmes, such as this, expected to achieve the same standard of competence on a reduced number of assessments.

Participants' anticipated outcomes of their training can be further explored by utilising one of the cycles of change within PCT – the 'experience cycle' (Kelly 1955, as cited in Fransella & Dalton, 2000, Figure 2).

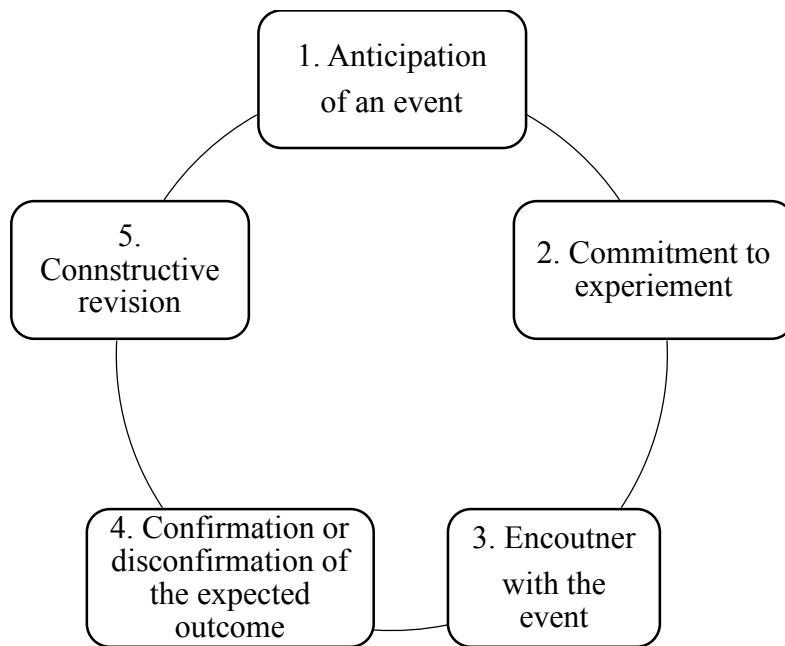


Figure 2. The experience cycle (Kelly 1955, as cited in Fransella & Dalton, 2000).

This cycle may reflect the results observed within this study, describing the journey of training and anticipated accreditation in CBT. The ‘commitment’ phase may reflect individual’s commencement of their CBT training, and a transition to the ‘encounter’ stage develops with further knowledge of the skills within CBT. As participants become more aware of the depth of CBT and the requirements for accreditation, it is possible that their anticipated expectation of becoming an ‘Ideal therapist’ is disconfirmed. It could be hypothesized that given time to consolidate their skills, and the opportunity for further training and supervised practice, participants may have different experiences within the ‘encounter’ phase, which will ultimately shape their construal of their own competence and professional development.

Strengths and limitations of this study

There are some methodological issues that should be considered in relation to the outcomes reported in this study. The participants in this study were all female, the majority being from

a nursing background and from one cohort from one Diploma-level course in CBT; therefore, the findings may not generalise to other students and courses.

This is the first study of CBT students on a BABCP accredited programme in Wales and the results are particularly interesting in a Welsh context. The experiences of students on programmes in other countries within the UK and beyond may be different (in this study all participants but one were working in Wales).

A specific methodological issue was that there was not a limit given on the number of constructs created in the pre training interviews. In the post training interviews, participants were limited to creating 10 constructs, and if the same limit had been imposed in the pre training interviews, further statistical analyses could have been performed.

It should be highlighted that the repertory grid technique forces participants to indicate differences between the elements by ranking them. The data created from repertory grids is ordinal and therefore, unlike interval data, equidistance between each ranking cannot be assumed. Therefore, participants may not see a difference between elements, and it is unclear how great the difference is between individual elements.

Finally, this study is not a traditional pre and post comparison experiment. Practice effects may have been a confounding variable in the development of constructs and the construal of elements in the post training interviews. Other confounding variables may include the variations in participants' previous experience and training in CBT, perceived competences, and personal circumstances – all which may influence the ranking of elements and the development of constructs within repertory grid.

With regards to methodological strengths, the repertory grid technique allows for minimum researcher bias, as there is no interpretation of the information provided by the participants during interview. Repertory grids are compiled solely of the language of the participants, capturing the dynamic nature of individuals' ways of construing and

understanding themselves and the world around them. The repertory grid technique also provides researchers with a large amount of quantitative and qualitative data that can be analysed at an individual or group level.

Implications and future research

This research indicated simple steps that could improve the student experience, including highlighting the similarities and differences between Level One and Level Two BABCP accredited programmes, and offering a feedback session to discuss assessment results. These have now been implemented within the Cardiff University CBT training programmes.

An exploration of how to review and measure the construal of students' personal and professional development more regularly may also provide valuable feedback to training courses and services regarding how best to help support and encourage such development during and after CBT training. As presented within the introduction, traditional measures of passing CBT training courses tend to operationalize competence in an objective way, led by trainers and supervisors. In 2009, Mathieson, Barnfield and Beaumont asked postgraduate CBT students to self-rate their competence on a CTS-R, and compared these ratings with supervisor-rated competence and other-rated competence. Results reported a non-significant relationship between the students' self-assessment of their competence and supervisor-rated competence and other-rated competence. However, the authors argued that self-assessment of competence provides useful information regarding students' confidence development. Focusing on supervisor-led assessment tools may neglect the valuable contribution that students' can bring to their own competency development.

Future research could explore students' perceptions of their competence, development and training experience one year after completing their training, or once accreditation has been obtained. This would provide students with an opportunity to consolidate their new skills. It

could be hypothesized that after this time, students may feel closer to their construal of an ‘Ideal therapist’ as they are officially recognised by their governing and professional body and may be in a different stage of competency development. This could also extend to include the whole range of the CBT training journey including the experience of postgraduate Certificate training, then Diploma-level training and then once accreditation has been obtained.

The results of this study also have wider, service-level implications for staff working in mental health services. Within Wales, the ‘Together for Mental Health’ strategy (Welsh Assembly Government, 2012) highlights the importance of improving the capability, attitudes and values of staff who work in mental health services. The results from this study show that CBT training has improved staff capability and by the time of writing, all students had passed the course, including a competency based rating of an audiotape of their practice (CTS-R) which was marked and moderated according to University standards. Additionally, the results from this study show that CBT training has impacted on the attitudes and values of staff, as their views on what is an ‘Ideal therapist’ changed during training and they have shown greater humility regarding their own skills.

Future research should also explore the impact of the perceived lack of competence by students after their Diploma-level training and its relationship to clients’ experiences and outcomes of therapy.

Given that the majority of the previous research into CBT training has focused on assessing competence development and skill acquisition, the repertory grid method could be employed routinely across various training programmes to compare students’ construal of their own competence, which could then be compared to formal measures of assessment such as scores on the CTS-R.

Finally, exploring and comparing the experience of CBT training across the UK may also allow for courses to highlight areas of excellence as well as elements that could be improved to provide a better training experience for students.

Conclusion

This study provides an insight into the experience of CBT training and specifically, what is happening within trainees as their external competence increases. Students' capability increased, and changes were noted in their perceptions of an 'Ideal therapist' and an increased use of 'Intellectual/ Operational' constructs. These findings indicate that staff development had occurred in line with the recommendations of the 'Together for Mental Health' strategy (Welsh Assembly Government, 2012) during this postgraduate Diploma-level course in CBT.

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Paper 3: A Critical Evaluation and Reflection on this Research

Word count (excluding References): 8466

Introduction

This paper presents a critical evaluation and reflection of the research undertaken as part of this thesis. The first paper is a systematic review conducted on the experience of Cognitive Behavioural Therapy (CBT) training and the second paper is an empirical study of the exploration of the construal of CBT students' personal and professional development during training. Implications of this research on the wider field of CBT training, including the commissioning of courses are discussed, as well as the dissemination of this research. Personal reflections on the overall research process is commented on throughout and summarised at the end. Given that the research topic of this thesis is an exploration the experience of one type of professional training, a personal reflection on my own experience of professional training is provided, including the impact this research has had on my own personal and professional development, as well as my clinical practice both during and after training. Reflections are linked to the results from the empirical study, offering similarities and differences between the experience of two forms of professional, postgraduate training.

Paper 1: The Systematic Review

Rationale for the topic

The development of this thesis began with ideas for the empirical paper. The focus of the empirical paper, exploring the construal of CBT students' personal and professional development, appeared to fit within a context of exploring and reviewing the research conducted on the experiences of CBT training thus far. Initial, brief searches revealed that the majority of published literature on CBT training focused on the acquisition and development of competencies in CBT. Research focuses included students' perceptions of their own

competence (Bennett-Levy & Beedie, 2007), exploring what components of CBT training that students perceive increased their competence (Bennet-Levy, McManus, Westling & Fennell, 2009; Rakovshik & McManus, 2013) and methods of assessing and measuring competence (Muse & McManus, 2016). A systematic review had been conducted on the research exploring methods of assessing competence in CBT (Muse & McManus, 2013) and a meta-synthesis of the qualitative literature on the experiences of self-practice/self-reflection (SP/SR, a component of many CBT training programmes) had also been published (Gale & Schröder, 2014). A synthesis of the research regarding the experience of CBT training appeared to be absent from the literature.

Literature search (including inclusion and exclusion criteria)

As generic searches were undertaken of the literature on CBT training, it became clear that there was a lack of research focusing solely on the perception of CBT training from students' perspectives. Whilst this was encouraging for the introduction of the empirical study of this thesis into the literature, it was also difficult to formalise inclusion and exclusion criteria for the systematic review. Initially, discussions with the research supervisors of this project led to the agreement that studies would only be included in the review if the research context was within a postgraduate level, accredited CBT training course. Exclusions were initially agreed upon as studies that explored CBT training as part of psychiatry training, shorter courses in CBT and continuing professional development (CPD) workshops. Once initial searches began, it became clear that there was not sufficient published research on such accredited courses, and as a result, the inclusion criteria were expanded to include the experience of any CBT training course. It was agreed at this stage however, that studies should only be included if they were published no later than the year 1990, as the Cardiff University CBT programme lead (LW) involved in this research agreed that CBT training was more formally established

from this time point onwards, mainly due to the growth of the British Association for Behavioural and Cognitive Psychotherapists (BABCP) and the implementation of its accreditation standards and procedure.

Studies were only included in the systematic review if they were published in a peer-reviewed journal. Whilst this ensured that all the studies included were of a good quality standard, there is a possibility of some publication biases being present within the findings that were reviewed. Grey literature (conference presentations, dissertation abstracts) or reviews were also excluded for rigour and relevance reasons, but this may have omitted additional aspects of understanding of the topic.

One surprise during the literature search was the apparent absence of the students' perspectives in CBT training research. Supervisors' and trainers' perspectives of CBT training and its methods, did not fit within the context of this research and therefore, such studies were excluded from the systematic review as it aimed to capture an un-biased representation of students' perspectives and experiences of training.

The literature searches produced many studies that arguably reported on students' experiences, but experiences were often focused on one specific element of training. The most frequent example of this was studies exploring SP/SR. Discussions were had regarding whether the inclusion of such studies would be too specific for this general account of the experience of CBT training. Difficulties arose in this decision as SP/SR is not a mandatory component of every CBT training course (for example, it is not an explicit element of the Cardiff University CBT training programme). However, once I read more about SP/SR and its wide-spread literature base (including a meta-synthesis review), it was agreed that the studies relating to SP/SR would be included in the review as it appeared to be a prominent component of many CBT training programmes, and widely researched in different countries

including the UK (Chaddock, Thwaites, Bennett-Levy & Freeston, 2014) and Australia (Bennett-Levy & Lee, 2014; Bennett-Levy *et al.*, 2015; Spafford & Haarhoff, 2015).

Quality assessment

The quality assessment tool for studies with diverse designs (QATSDD, Sirriyeh, Lawton, Gardner & Armitage, 2012) was chosen for this systematic review as it is a validated measure, used in a variety of research studies and contexts (Albutt, O'Hara, Conner, Fletcher, & Lawton, 2016; Harris *et al.*, 2016). All studies included in the systematic review were rated independently by two assessors (myself, HJ) and a colleague not affiliated with this research (JA). I was pleasantly surprised when our ratings were revealed and they were similar across all studies. If discrepancies had been shown between the categorisation of the quality ratings (i.e. high, moderate or poor quality), then a meeting would have taken place to discuss the justifications for each rating and to reach a coherent agreement.

Rating the studies included in this systematic review was a challenge. Firstly, despite the QATSDD being developed to assess mixed method studies, the variation between each study's design and outcome measures made it difficult to remain consistent. Therefore, a choice was made to have the independent assessor rate all the included studies in the systematic review for optimum reliability (as opposed to a certain percentage of the studies). Secondly, there did not appear to be an obvious, clear narrative thread throughout the studies involved. To remind myself of the systematic review aims, I had to utilise several research supervision sessions with the research supervisors effectively. This enabled me to appreciate that any research project undertaken has its limitations, and just because an area of literature does not appear coherent, does not mean it cannot be synthesised for a meaningful review.

Synthesising the data

Due to the variation in methodologies and outcome measures, a narrative synthesis of the findings of the studies was required. This proved to be difficult, as although the included studies explored or commented on some form of student experiences of CBT training, all had a very different focus. This not only made it difficult to compare the studies in terms of their quality and overall contribution to the understanding of the topic, but it also made the findings challenging to synthesise.

There were several potential ways of synthesising the data from the studies in the systematic review, other than the process reported in the first paper. One alternative that was considered was to group studies together based on the type of CBT training that was reported; for example, postgraduate CBT training affiliated with a University, CBT workshops, short CBT courses, and CBT teaching and supervision within general psychiatry training. It was decided that this method of synthesising would not be pursued, due to the variation in the structure, format and content of CBT training across many different contexts and countries. There was no certainty that the courses which could have been ‘grouped’ together would have been homogenous or comparable. Further deliberation led to the decision to synthesise the data based on their research aim and focus, yielding four themes to describe the findings; the exploration of SP/SR, internal processes throughout CBT training, perceived effective components of CBT training, and general satisfaction with CBT training. At this stage, the rationale for conducting the empirical study within this field of research was reinforced, as there was nothing of its kind within the systematic review and the narrative synthesis themes.

Clinical implications, future research and conclusions

The conclusions of the systematic review stated that further, scientific, research, solely focusing on CBT training is needed to fully understand students’ experiences. Whilst the

empirical study of this thesis focused on professional, postgraduate, Diploma-level CBT training, the systematic review revealed that CBT training in other course structures and forms could be improved, particularly as part of psychiatry training. It is a concern that individuals may undertake a brief course or workshop in CBT and then, upon completion, believe that they are fully skilled and competent to deliver formal CBT as part of a therapeutic intervention. The accreditation standards of the BABCP have provided a professional framework and guidance to safeguard individuals from receiving such sub-standard CBT, however, I believe that this needs to be conveyed more strongly to service-users and carers. Whilst the ‘stepped care’ approach of psychological services is widespread across the National Health Service (NHS) in Wales and the rest of the UK (Bower & Gilbody, 2005), service providers should be aware that contrary to the conclusions made by Wampold (2001) who described the ‘Dodo bird effect’ of psychotherapy (concluding that two types of psychological therapy - CBT and psychodynamic psychotherapy, are equally as effective as each other), more recent research has shown that carefully selecting clients to undertake particular models of therapy is crucial for positive, long-term results (Fonagy, 2010). This means that firstly, stepped care services need to ensure that CBT training provided to staff is adequate for clients’ needs. This is stated in the ‘Increasing Access to Psychological Therapies’ (IAPT) initiative, descriptions of high and low intensity therapists (Clark *et al.*, 2009) and the Scottish Matrix (National Health Service Education for Scotland, NES, 2011, 2015) and the Welsh ‘Matrics Cymru’ (National Psychological Therapies Management Group & Public Health Wales, 2016) guidance regarding level A, B and C practitioners. Secondly, services need to ensure that practitioners carefully select the appropriate modality of therapy for clients and work to their own competency and ability frameworks.

Finally, the implications of this research provide evidence for the principal and importance of ‘co-production’. The co-production of services between professionals and patient and public involvement is constantly increasing in health care research (Gillard, Simons, Turner, Lucock & Edwards, 2012) and is a growing requirement in national guidance and frameworks for mental health services (National Development Team for Inclusion, 2016). This systematic review highlights the need for co-production within professional training courses, with students’ views and recommendations incorporated into the design, structure and format of training programmes. To provide this perspective, a better understanding is needed regarding students experience of CBT training to date, so that suitable recommendations can be made to enhance the effectiveness of training courses in improving students’ skills and competence, but also to provide a positive experience of training for students. This is of particular interest not only to training course providers, but also to the commissioners of psychological services, as research has shown that competency in CBT leads to positive patient outcomes (Trepka, Rees, Shapiro, Hardy & Barkham, 2004; Rakovshik & McManus, 2010).

Paper 2: The Empirical Paper

Identification of the research topic

At the time of choosing a research topic and question for this thesis, the National Psychological Therapies Management Group & Public Health Wales had released an initial draft of ‘The Matrics Cymru’ (2016) for consultation across Wales. Having worked within the Welsh NHS before my Doctoral training, I was keen to explore this publication further and consider how it may impact on the services that I had been a part of and hoped to be

delivering after qualification. Following the implementation of the 'IAPT' initiative (Clark *et al.*, 2009) in England and the development of 'The Matrix' in Scotland (National Health Service Education for Scotland, NES, 2011, 2015), I was hopeful that the 'Matrics Cymru' would provide Wales with an evidence-based framework, with support from Welsh Government, to guide the commissioning and delivery of psychological services across the country.

I anticipated that this guidance may have mixed reactions from various professionals and I was keen to capture these various perspectives in the form of a thesis. After many discussions with the Doctoral course staff, the lead author of the 'Matrics Cymru' and Clinical Psychologists working within Wales, it transpired that this project appeared too ambitious for a thesis in this context. Reasons for this included; the requirement of a complicated ethical approval process, as the need for an all-Wales perspective would have meant applying for ethical approval in all of the seven Health Boards across Wales; a difficult process of data collection across a vast geographical area; and finally, to obtain a homogenous perspective of the implementation of the 'Matrics Cymru' would have in itself created problems, as services delivering psychological therapies across Wales are very different, due to the variations in resources, funding and client demographics.

The initial discussions with various individuals regarding this ambitious project eventually led to the development of the current research topic. The 'Matrics Cymru' had outlined that individuals experiencing 'moderate-severe' mental health problems should have access to a 'high intensity specialist intervention' delivered by practitioners who have achieved, at least, Diploma-level training. I was aware that at the time of writing, the postgraduate Certificate and Diploma courses in CBT at Cardiff University were the only programmes in Wales delivering CBT training that was accredited by the BABCP. When I discovered that no research had been undertaken to date on CBT training in Wales, this felt like a timely

opportunity to explore this postgraduate training programme and relate the findings to the political context both in Wales and across the UK.

Meetings were held with the CBT Programme Lead (LW) and it was agreed that this area of research was feasible. Initial discussions took place to potentially explore students undertaking their Certificate and those undertaking their Diploma in CBT; however, it was advised that choosing either Certificate or Diploma-level students would produce a more homogenous sample for research purposes. During discussions, it was decided that the Diploma-level students would arguably be the most interesting group to study as they were coming towards the end of their postgraduate training in CBT and were closer to full accreditation once the course was complete.

After this meeting, I consulted the literature to explore what research had already been conducted thus far within the field of postgraduate CBT training. As described above, research appeared to focus on competence and skill acquisition during professional postgraduate training (McManus Westbrook, Vazquez-Montes, Fennell & Kennerley, 2010; Rakovshik & McManus 2013). Therefore, I decided to focus on the experience of CBT training, from student's perspectives. This was also an interesting research question personally, as I too was experiencing professional training (in Clinical Psychology), during the whole research process. This made me intrigued to discover whether I felt I could relate to the participants and to explore their experiences of a different type of postgraduate, professional training in comparison to my own.

The methodology and design

Initially, methodological ideas involving the development of a survey that could be sent to past students were discussed, however, this had already been undertaken (MacLiam, 2015) and it was agreed that a deeper level of understanding was needed as opposed to a descriptive

account of satisfaction with training. This led to the consideration of conducting individual interviews with students after their training was complete and then to analyse the data utilising a qualitative method, such as a grounded theory approach (Strauss & Corbin, 1997), to create a theory of the internal processes and overall experience of students undertaking Diploma-level CBT training. As I explored the literature further, I discovered that whilst there had not been a study conducted that explored what CBT training is like for students, with no pre-determined focuses or themes, research had already explored some aspects of CBT training using a grounded theory approach before (Bennett-Levy & Beedie, 2007; Bennett-Levy & Lee, 2014; Wolff & Auckenthaler, 2014).

At this stage, I was introduced to Personal Construct Theory (PCT, Kelly, 1955) and the repertory grid technique (Fransella, Bell & Bannister, 2004; Jankowicz, 2004). Whilst I had read a little about PCT and its application within a therapeutic context, I had not experienced its application within research. As my interest in this methodology grew through reading of various research studies that had utilised PCT and the repertory grid technique, I was excited by the breadth of information that the methodology could produce, in what appeared to be an objective, un-biased approach. I concluded that this methodology would provide the data I was hoping to explore, and more. I decided that whilst a single-time point data collection study would be of interest (and was following the same design as the previous psychology-related research that I had previously read that utilised repertory grids), a longitudinal design, collecting data from students pre and post CBT training, would provide a deeper understanding, not only of the general experience of CBT training, but also of any perceived change by the students during the course of their training. This prospect excited me, but also made me aware that my data collection point would need to be brought forward, and work needed to happen quickly, so not to miss the intake of the 2016 cohort for the Diploma in CBT course. If this project had been started earlier, it would have been of interest to follow

the journey of one cohort from their postgraduate Certificate in CBT, right through to the end of their postgraduate Diploma in CBT, and potentially further, once students had gained accreditation; this however, would have required at least two years of data collection.

To ensure I felt comfortable with conducting the repertory grid interviews, once I had read the guidance from Fransella, Bell and Bannister (2004) one of my research supervisors (DJH), highly experienced in the repertory grid technique, conducted a practice repertory grid with me. This was an important part of the research process to ensure I understood what it was like to be a participant, so I could explain the procedure as clearly and concisely as possible. Once I had experienced the repertory grid technique myself, I conducted a practice grid with another of my research supervisors (NT) as a trial run, ahead of the formal data collection. I was grateful for these practice experiences as they gave me confidence before I interviewed the participants in the study and allowed me to receive feedback regarding the way I explained the study's instructions.

Alternative methodological approaches that could have been employed for this study included a grounded theory approach (Strauss & Corbin, 1997) or interpretative phenomenological analysis (IPA, Smith, Flowers & Larkin, 2009). Whilst both of these methodologies would have provided great depth of data, a degree of researcher interpretation would have been required. The repertory grid technique is a valid method for exploring the underlying cognitions and thinking patterns of individuals, and no interpretation of participant data is needed for analysis, leading to minimum researcher bias (Ralley, Allot, Hare & Wittkowski, 2009). Previous literature has stated that research conducted on CBT training has often been a 'by-product' of research exploring the effectiveness and efficacy of CBT treatment (Rakovshik & McManus, 2010); therefore, the repertory grid technique felt like the best fit for this project methodology, to ensure an accurate, unbiased perspective was gained of student's experiences of CBT training. I also chose to utilise this methodology as it

was new to me, and I felt it would challenge my research skills, competencies and further my development, as opposed to utilising research methods in which I had some experience in before this project began.

Another area of the study's design that was discussed with the research team before the second round of data collection, was whether to interview participants before or after they had received their final results of the course. It was agreed that for completeness of the post training perspective, interviews should be conducted once participants knew whether they had passed the course or not. If the interviews had been conducted before results were given, different responses may have been observed. It is hypothesised that potentially further anxiety and uncertainty regarding the students' abilities may have been portrayed in the ranking of elements (i.e. 'Ideal therapist' possibly being further away from 'Actual self' as no formal feedback had been received on their overall course result).

Ethical approval

Obtaining ethical approval was relatively straightforward for this study. The application process was somewhat more complex than I had originally anticipated, with the finer details of certain components such as risk assessments, needing to be acknowledged throughout. Whilst this study did not focus on any seemingly distressing elements for participants, I was aware that the potential for causing distress should never be ruled out. To safeguard both the research team and the participants, contact details were given for myself (the researcher), the methodological supervisor (DJH) and Cardiff University's School of Psychology Research Ethics Committee secretary, so they could be contacted should any concerns be raised by participants. I also wanted to provide participants with as much information as possible about the study via the 'Participant Information Sheet', including the procedure and content of the

interviews, to try and alleviate any anxiety they might have had about participating in the study.

When interviews began, I was pleased to see that participants seemed to be engaged in the interview and appeared to be reflecting on elements that they had not explicitly considered before. Due to this observation, I reminded participants at the end of each interview (both pre and post training) of the contact information given on the 'Participant Information Sheet' should they wish to discuss anything further, and at the end of their participation in the study, provided them with a 'Debrief Form' which again provided these contact details.

Recruitment and data collection

To recruit participants in this study, I presented the proposed research study at the Diploma course student induction, before the course officially began. Only one participant declined to participate, therefore, the recruitment rate was fairly successful. Interviews were held either at Cardiff University or participants' place of work.

Engaging with participants was an enjoyable experience as none had experienced PCT or the repertory grid technique before and all were excited by this novel methodology. It was noted that to begin, participants appeared hesitant during their interviews to create the 'correct' construct, however, once they were further into the interview process, these anxieties seemed to subside and the personal emphasis of the repertory grid technique became clearer (i.e. participants appeared to accept that the grids were personal to them).

During the second round of interviews, many participants were intrigued to find out what constructs they had created in their first interview. This was promising as a researcher to hear, as I perceived that their eagerness to recall their first interview experience was their own way of reflecting on their process of change during their CBT training and suggested a degree of credibility that they felt towards the research methodology. Participants were not

told about their first interview constructs during the second interview, but they were sent their pre and post training completed grids, once data collection was complete.

Strengths and limitations of the study

Methodological strengths have been outlined in paper two, however, the study also had some practical strengths that made the research process easier for participants. Firstly, when ethical approval was initially sought for this study, it was stated that interviews would take place within Cardiff University. Once the participants were recruited, it became evident that they were based across a large geographical area, therefore, arranging the interviews at the University would have been difficult. Therefore, before the interviews were arranged, an amendment to the original study procedure was sent to the Cardiff University School of Psychology Ethics committee, requesting that participants were given the option to conduct the interviews at the University or at their place of work. Once this amendment was accepted by the Ethics committee, this proved a popular choice with the participants, allowing them to be more flexible in arranging the interviews. For the second round of data collection, all interviews took place at the participants' place of work.

One limitation of the study was that in the pre training interviews, participants were free to create as many constructs as they could. When analysing the data, I realised that not having a homogenous number of constructs between participants, meant that certain statistical analyses could not be performed across the pre training interview data or comparatively to the post training interview data. Therefore, if this study was repeated, a set number of constructs should be created at both interview time points.

Whilst the repertory grid technique provided various elements of useful data, I found myself intrigued to enquire further about participants responses, particularly during the second interviews, post training. As described above, individual pre and post training repertory grids

were typed up and sent to the participants after the research so they could compare the constructs they had created, as well as observe any differences in the ranking of the elements. If this study was to be repeated, it would be interesting to conduct a brief interview at this stage, for participants to reflect on their perspectives of change during their journey of CBT training. Qualitative data from these interviews could have been analysed using IPA methodology (Smith, Flowers & Larkin, 2009) or thematic analysis (Braun and Clarke, 2006) to enhance the understanding of CBT training experience. It is hoped that participants have found having their own copies of their pre and post training repertory grids helpful and interesting, and that they may utilise them in their further supervision sessions when reflecting on their own personal and professional development.

Implications

Supervisors and trainers on postgraduate CBT courses should be aware of the findings from this research and incorporate their implications into the development of training. In this study, as participants' construal of the 'Ideal therapist' changed significantly during the course of their training, this would be an interesting concept to explore within supervision sessions. Having the ability to reflect on what makes a good therapist shows evidence of participants' metacompetency skills, which is in line with the requirements and recommendations for CBT therapists (Department of Health, DoH, 2008). Providing students with feedback on a regular basis, as part of supervision during their training may also allow them to reflect on their perceptions of their own competence, which would hopefully be increased if course and accreditation standards are explicitly discussed regularly.

The results from this study are also of interest to training course commissioners. Undertaking professional training is a costly experience for individuals (practically in relation to the amount of time and extra study dedicated to training, as well as financially if an

individual self-funds their training), and for employers (by releasing staff from their clinical role to undertake their training, and financially if employers fund an individual's training).

The Cardiff University Diploma course in CBT comprises of 14 supervision sessions. The time committed to the practical aspects of the Cardiff University course structure is shorter than other postgraduate CBT training courses within the UK. For example, the Oxford Cognitive Therapy Centre postgraduate CBT comprises of 16 teaching days, plus bi-weekly supervision sessions for the course duration of one year (Postgraduate Diploma in Cognitive Behavioural Therapy, University of Oxford, n.d.). Whilst the duration and time commitment to these courses are different, both are accredited at Level One by the BABCP. This is interesting to note in relation to students' perceptions of their own competence, as the participants in this study are not only marked to the same criteria as courses offering a greater time commitment as described above, but also the same marking criteria is utilised for Level Two BABCP accredited courses. The difference between Level One and Level Two accredited courses is that the Level Two provides a greater quantity of training required to meet the BABCP's 'Minimum Training Standards' for accreditation (BABCP, 2015). The results from this study may suggest that whilst there appears to be little difference in the amount of skill, knowledge and competence gained from training courses that differ in their quantity, there may be a difference in students' perceptions of their own competence, as the participants in this study did not feel statistically significantly closer to the 'desirable' elements explored in this study. Commissioners should note that shorter courses appear to still provide students with the skills they require and an observed degree of humility regarding their own ability (as shown in this study), may benefit them as practitioners, and ensure they are keen to pursue further training and supervision after the course to obtain accreditation. It would be interesting to build on the research in CBT training to explore whether the students from a Level Two BABCP accredited course construe themselves and the 'desirable'

elements used in this study, in the same way as these participants from a Level One BABCP accredited course.

Although not statistically significant, some change was observed in the construal of the 'desirable' elements from pre training interviews to the post training interviews. This suggests that Diploma-level CBT training does change the way that students think. One of the modules of the Diploma course at Cardiff University is 'CBT Metacompetencies'. Defined by the DoH (2008), metacompetencies are over-arching, higher-order competencies, which requires individuals to make links between theory and practice to plan and if needed, adapt therapy to individual clients. The 'Cardiff University Postgraduate CBT Programme Handbook' describes the specific learning objectives from the metacompetencies module as; implementing CBT in a manner consonant with its underlying philosophy, formulating and applying CBT models to the client, selecting and applying the most appropriate CBT method, structuring sessions and maintaining appropriating pacing and managing obstacles to CBT therapy.

Fransella (1975) describes cognitive complexity as an ability to make sense of more complex systems. Arguably, this ability to reduce down complex systems to make an understanding is an essential component of metacompetencies in CBT. The results from this study could be interpreted as evidence of participants' cognitive complexity, as results displayed a change in their thinking and construal of constructs and elements throughout the course of the Diploma-level training in CBT. This was most evident in the statistically significant difference observed in the construal of the 'Ideal theapist' pre and post training. This shows participants have the reflective ability and awareness to consider what constitutes as best practice; a skill which will ensure they continue to deliver effective CBT after their training.

Dissemination beyond publication

The presented systematic review within this thesis will be submitted for publication to the ‘Behavioural and Cognitive Psychotherapy’ journal and the empirical study presented will be submitted for publication to the ‘Clinical Psychology and Psychotherapy’ journal. The decision to publish in these journals was collaborative between the research team, and consideration was given to the journal’s impact factors as well as the content relevance and potential readers.

The results of the empirical study have already been disseminated at an international conference. In June 2016, when the first round of data collection and analysis was complete, I applied to present the empirical paper at the annual British Psychological Society (BPS) Division of Clinical Psychology conference. I was successful in obtaining a presentation slot in the ‘rapid communications’ section of the conference, giving me 15 minutes to present the project. This time constraint was a challenge as once the second round of interviews were completed in October 2016, I understood just how much data I had and how much could potentially be analysed and reported on. The experience of writing this presentation prepared me well for writing up the empirical paper for publication, as it taught me to be concise and scientific in my writing style. The presentation took place on 19th January 2017, in Liverpool, in front of around 50 delegates at the conference. Following the presentation, I received positive feedback from fellow delegates, particularly for presenting a concise account of PCT and the repertory grid technique for context, as well as all the study’s rationale, description, findings and implications, all within the allotted time slot.

Whilst the systematic review has not yet been disseminated further, I plan to seek out CBT specific opportunities (such as conferences and national guidance consultations) to contribute the findings and conclusions of the review to an audience with a specific interest and investment in CBT.

Professional and personal impact of the empirical study

It is encouraging to see that results from this research have already had an impact on the structure and content of the postgraduate Diploma course in CBT at Cardiff University. Once the results had been fed back to the Programme Lead, and discussions had taken place to explore why such results were found, changes were implemented immediately for future cohorts of the training programme. As it was hypothesised that students may not have been aware of the differences between Level One and Level Two accredited training courses, these are now explicitly discussed with students across both their Certificate and Diploma-level training.

In this study, the post training interviews were conducted once results from the course had been given. Due to the finding that individuals did not feel significantly closer to their construal of an 'Ideal therapist', it was hypothesised that despite having their results, students still felt as though they had further work to undertake to become their perception of the 'Ideal therapist'. It was agreed that a meeting with their course supervisor once they had been given their results may give students a space to reflect on their achievements throughout their training and receive individual feedback regarding their progress. At this interview, any concerns or worries regarding applying for accreditation in the future could be discussed, hopefully giving students more confidence in their own abilities and accomplishments over the course of their training and beyond. This post results meeting has now been set up and agreed with the course supervisors, and will be offered to all students from 2017 onwards.

Conducting and writing up this research has been personally rewarding to see that it has had a practical impact on the future of CBT training in Wales. It is hoped that once published, other courses may consider offering similar components within their courses, if they are not present already. Ultimately, these changes are aiming to increase students' confidence and

perception of their own CBT competence, in the hope that CBT students will be keen to pursue further training and supervision that will lead to full accreditation.

This research is the first of its kind within Wales. It has been exciting to undertake such an experiment in an interesting political time, when the NHS and psychological services are experiencing high levels of pressure and change. This research has led to further lines of enquiry within the CBT training field, and it is understood that now a fellow Doctoral student in Clinical Psychology is planning to undertake a similar study in Wales with students completing their Certificate-level training in CBT. In the future, it would be interesting to conduct a comparison study between the students at these two levels of training, to see whether there is a difference in the construal of elements and the perceived level of change on the Certificate course compared to the Diploma-level course.

Since this research project, and learning and applying the methodology, I have utilised both PCT and the repertory grid technique in my clinical placement work. In meetings regarding the development and implementation of a new psychological therapy group within inpatient services, I have suggested to Heads of Service and other staff that PCT and the repertory grid technique would be an effective and useful methodology to capture group members' perceptions of themselves, pre and post an intervention and measure any perceived change. It is hoped that these evaluation techniques will be utilised to inform commissioners and the Welsh Assembly Government of the impacts of such an intervention.

Personal reflection on the overall research process

The journey of conducting this thesis has been a challenging but exciting experience. The process has particularly tested my time management skills, as throughout the process I have also had to juggle the other components of my professional training, including academic

assignments, coursework, and clinical placements. Whilst this made the research process difficult at times, I felt it was good preparation for the reality of work post qualifying, as clinical work is not the sole job or responsibility of a Clinical Psychologist. As my research focused on the experiences of CBT students, it was different to be working with a staff group within a clinical and academic setting, as the majority of my clinical work has been directly with client groups.

The topic of this research project has also allowed me to acknowledge and reflect on my own personal and professional development aside from formal competency measures used as part of the assessment of my ability and progress during training. Research has found that this is often difficult during a busy professional training programme with multiple components and demands (Hill, Wittkowski, Hodgkinson, Bell & Hare, 2015).

I have found that during this research process, there have been things that have helped me manage my experience of stress. One aspect has been to utilise research supervision effectively. During the research process, I was keen to be prepared for each supervision session, always bringing my questions and reflections to discuss as a research team. I found that documenting the content and discussions of every research supervision session in a diary helped my thought processes throughout the thesis journey, particularly during the initial stages of the research topic and question development. The process of research supervision has opened my experiences to a different type of supervision, which I feel will help in my future career, particularly when supervising others. I was surprised to find myself often “expecting the worst” ahead of supervision sessions, but the support from each of my supervisors helped me manage these emotions, and I was grateful for the different elements, contributions and perspectives that each supervisor brought to the research journey.

An important moment for me during this research project was presenting it in the BPS Division of Clinical Psychology conference, in January 2017, in Liverpool. When I applied in

June 2016 to present the empirical study's findings, I had never done anything of this nature in my professional career to date. Whilst I was apprehensive and nervous about the presentation, I felt the experience it gave me was invaluable for my future, post qualifying. It not only taught me how to deliver a large amount of information in a short amount of time, but also gave me an experience of presenting research at an international conference. I also feel that having to present my results in January 2017 gave me an initiative to start my data analysis as soon as the data was collected; helping me to utilise my time management skills effectively so that I could give my full attention to the analysis, and not feel rushed in generating my conclusions. As I had not read a repertory grid study in the field of psychology that had utilised a longitudinal design, and I had collected data at two time points, I felt excited at the prospect of analysing and writing up the research findings. I am glad I started this process early, due to the amount of information and data the repertory grids could provide.

Conducting this thesis has given me the confidence and enthusiasm to pursue research further, once I have qualified as a Clinical Psychologist. Whilst I know this ambition will bring with it challenges in the professional context of the NHS, conducting this study has allowed me to see first-hand the practical benefits that undertaking research has on individuals, services and commissioners. I have found that in my current clinical work, particularly since beginning to write this thesis, I have placed a strong emphasis on outcome measures, and ensuring that anything that professionals undertake, whether it is clinical work or indirect work, is evaluated. I believe this focus will stay with me once I qualify and work in a busy NHS setting, and I will strive to always include the 'clients voice' in my work, as I have strived to portray the 'students voice' during this research project.

Personal reflection on my own experience of professional training

Whilst undertaking this project, and exploring the experiences of students undertaking one type of professional, postgraduate training, I have found myself reflecting on my own experience of professional postgraduate training throughout the process.

Despite being in a different type of professional training to the participants in this study, I feel I have had similar experiences in relation to the construal of my personal and professional self throughout the journey of my Doctoral training in Clinical Psychology. Placing my experiences within a theoretical understanding, before my training began in September 2014, I believe I was in the ‘unconscious incompetence’ stage of the Conscious Competence Learning Model (Conscious Competence Learning Model, n.d.). I had experienced working in clinical settings, and had utilised basic CBT within individual, group and community interventions. As a result, I was aware that I was knowledgeable in the theory and clinical application of the model. Whilst I was aware of other psychological models, they were mainly, ‘third wave’ CBT models and, similarly, I felt that I understood their underlying principles and some basic methods of their application. There were some areas of psychological practice of which I had no experience at all, such as consultation.

As I started my training, I was introduced to the world of applied professional clinical psychology and I feel I moved into the ‘conscious incompetence’ stage of learning. The teaching I received on psychological models such as CBT showed me that there was much more to therapeutic interventions that I had not yet experienced, and I felt a sense of being ‘stripped back’ from my previous understanding during the initial months of my Doctoral training. For example, I recall feeling as though before training I was utilising CBT, but with a strong behavioural focus, rather than a balanced proportion of the cognitive and behavioural elements of change. This led me to feel as though I had to ‘re-learn’ and re-construe my understanding of CBT given this new information.

An area that I was excited about, yet slightly daunted to explore, was psychological formulation. The practical element of applying psychological formulation within my clinical placements (particularly during my first year of training) allowed me to see its importance as not only providing individuals with a collaboratively created understanding of their difficulties, but also the utilisation of formulation as an agent of change within an intervention.

It should be noted that whilst I feel some similarity to the experiences of the participants in this study, Clinical Psychology training and postgraduate CBT training are very different. Typically, the students undertaking a Diploma-level CBT course are working clinically within the NHS, however, the direct link of their training to their clinical work is not as clear as it is within Clinical Psychology, where the training programme identifies clinical placements, and assesses various aspects of clinical work as well as academic assignments and research. It is possible that the CBT students in this study may have felt more stressed than myself as their training and clinical work may have felt more separate, leading to potential competing demands with no obvious link.

In 2015, Hill *et al.*, conducted a repertory grid study on trainee Clinical Psychologists in their final year of training. Results found that trainees had low self-esteem and were at the time, feeling stressed, anxious and that they lacked a work-life balance. The findings reported that these difficulties were attributed to the demands of their training, but that participants anticipated that such feelings would subside once training was complete. Similarly, there have been times that I have shared the same feelings and experiences as the participants in the study conducted by Hill *et al.* (2015), however, during these times I have found utilising supervision on my clinical placements and engaging in group reflective practice within my cohort has helped me manage such feelings. Hill *et al.* (2015), recommended that the normalisation of stress during training should be encouraged and a focus on self-care and

personal development should also be an integral part of training. Whilst it has been outlined that Doctoral training in Clinical Psychology and postgraduate training in CBT are different, the conclusions from this thesis indirectly support this recommendation for CBT training programmes as well. The role of supervisors in providing feedback to students and the emphasis of BABCP marking and accreditation standards being shared with students throughout training shows that normalising stress and understanding expectations are being addressed – something that will, hopefully, impact positively on students personal development as well as their management of stress during training.

There are certain elements of my professional training that I feel I am now closer to the ‘Ideal psychologist’ than other elements. Skills such as research, audit and service evaluation are components I have enjoyed and appreciated throughout my training, particularly given the varied opportunities I have had to practically apply such skills (including experience of using quantitative and qualitative methods in small scale and larger research projects). These skills include; concise, scientific writing; presentation skills and an increase in my confidence and competence in disseminating and contributing to service improvement and the evidence within the field of clinical psychology. The application of these skills has heavily influenced my own personal and professional development as many opportunities have arisen as a result of my experiences.

The participants in this study showed evidence of a cognitively complex change during their training, in the understanding and construal of what it means to be the ‘Ideal therapist’. It is possible that in the same way I felt training opened my mind to the vast range of skills and competencies that a Clinical Psychologist has, the Diploma-level training course in CBT arguably provided participants with a deeper understanding of the complexity of CBT, not only as a psychological model, but also the importance of metacompetencies, to guide practitioners in the implementation of any intervention.

Whilst the participants in this study developed more ‘Intellectual/Operational’ constructs post CBT training, Hill *et al.* (2015), showed that trainee clinical psychologists created more ‘Personal’ constructs in their final year of their training. This difference is interesting to note and possibly highlights the different mentalities and perceptions that individuals have about the important elements of being a CBT therapist compared to a trainee clinical psychologist. Applying this finding to a practical context within the NHS, band seven posts are often filled by a Clinical Psychologist or a CBT therapist (Agenda for Change, Department of Health, 2004) within psychological services. Whilst this may lead commissioners and service providers to believe that the two roles offer a similar set of attributes (namely therapeutic skills), this research shows that the mentality and construal of the two roles are different. Commissioners should take this into account when developing posts to ensure that they have the correct professional for the role required.

Similarly to the participants in this study, I do not yet feel that I am the ‘Ideal clinical psychologist’, nor do I feel I have transitioned fully into the ‘conscious competence’ phase of learning in all aspects of my role as a Clinical Psychologist. Conducting this research project however, has allowed me to reflect on and accept that any form of professional training is a journey, and it does not necessarily leave you feeling like ‘the finished article’ or the ‘Ideal therapist/psychologist’. Consulting the literature and professional guidance on CBT training and discovering that further supervised practice, training and development is required after training has encouraged me to ensure that post qualifying, I continue to develop myself both personally and professionally. This research project, and the opportunities that have arisen from it have given me the confidence to pursue various opportunities, particularly opportunities that I have not experienced before. The journey of exploring this topic and considering different methodologies to utilise for this research has taught me to always be curious about alternative methods of undertaking a task, intervention or skill, and has

encouraged me to think innovatively in the delivery of psychological services, and similarly to the participants in this study, develop my own metacompetency skills. For me, these concluding reflections and feelings evidence that professional training has impacted significantly on my own personal and professional development, and I feel excited about the prospect of taking my broad training experiences into the role of a qualified Clinical Psychologist.

Conclusion

The first two papers within this thesis present a depiction into what it is like to undertake professional, postgraduate training in CBT. Whilst research has concluded that CBT training is effective and provides students the opportunity to enhance their skills, knowledge and competence, research has often failed to provide a clear understanding of students' experiences of CBT training with no pre-determined themes or focuses to date.

The study of CBT students' construal of their personal and professional development aimed to explore various elements of students' experience, competence and development throughout their journey of training. Diploma-level CBT students may not feel that they are the 'Ideal therapist' after their training, but their understanding of what an 'Ideal therapist' is, changes during the course of training. This arguably provides evidence that students are actively involved in a cognitive complex construal of what makes an effective CBT therapist and what constitutes as best practice.

Personally, I have experienced similar feelings to those reported by the participants in this study during my own professional training journey. Both my own reflections and the results from the empirical study suggest that whilst training provides a good opportunity to further knowledge and skills, personal and professional development are a constant feature in a

professional career, and further supervision, training and experience is needed to feel closer to perceptions of an 'Ideal professional'.

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Appendix 1:

Author Guidelines for the Behavioural and Cognitive Psychotherapy Journal

Instructions for contributors

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Behavioural and Cognitive Psychotherapy is an international multidisciplinary journal for the publication of original research, of an experimental or clinical nature, that contributes to the theory, practice and evaluation of behaviour therapy. As such, the scope of the journal is very broad and articles relevant to most areas of human behaviour and human experience, which would be of interest to members of the helping and teaching professions, will be considered for publication.

As an applied science, the concepts, methodology and techniques of behavioural psychotherapy continue to change. The journal seeks both to reflect and to influence those changes. While the emphasis is placed on empirical research, articles concerned with important theoretical and methodological issues as well as evaluative reviews of the behavioural literature are also published. In addition, given the emphasis of behaviour therapy on the experimental investigation of the single case, the journal from time to time publishes case studies using single case experimental designs. For the majority of designs this should include a baseline period with repeated measures; in all instances the nature of the quantitative data and the intervention must be clearly specified. Other types of case report can be submitted for the Brief Clinical Reports section.

The following types of articles are suitable for *Behavioural and Cognitive Psychotherapy*:

- Reports of original research employing experimental or correlational methods and using within or between subject designs.
- Review or discussion articles that are based on empirical data and that have important new theoretical, conceptual or applied implications.
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The accelerated publication section is intended to accommodate a small number of important papers. Such papers will include major new findings for which rapid dissemination would be of considerable benefit and impact. For example: reports of the results of important new clinical trials; innovative experimental results with major implications for theory or practice; other work of unusually high calibre. If submitting a manuscript to this section you must specify in your cover letter why it should be considered as Accelerated.

Empirically Grounded Clinical Interventions

This section is intended for reviews of the present status of treatment approaches for specific psychological problems. It is intended that such articles will draw upon a combination of treatment trials, experimental evidence and other research, and be firmly founded in phenomenology. It should take account of, but also go beyond, treatment outcome data.

Brief Clinical Reports

Material suitable for this section includes unusual case reports and accounts of potentially important techniques, phenomena or observations; for example, descriptions of previously unreported techniques, outlines of available treatment manuals, descriptions of innovative variations of existing procedures, details of self-help or training packages, and accounts of the application of existing techniques in novel settings. The brief clinical reports section is intended to extend the scope of the clinical section. Submissions to this section should be no longer than 1800 words and should include no more than six references, one table or figure, and an extended report that contains fuller details. There are no restrictions on the size or format of the extended report as it will be published online only. It may, for instance, be a treatment manual, a fully detailed case report, or a therapy transcript. If a submission is accepted for publication as a Brief Clinical Report, the author(s) must be prepared to send the fuller document to those requesting it, free of charge or at a price agreed with the editor to reflect the cost of materials involved. The extended document will also be mounted on the journal's website www.cambridge.org/core/journals/behavioural-and-cognitive-psychotherapy and therefore we require an electronic version in Word or PDF format (the document will not be copyedited).

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Articles must be under 5,000 words at the point of submission, excluding references, tables and figures (except for Brief Clinical Reports, please see separate instructions). Manuscripts describing more than one study may exceed this limit but please mention this in your cover letter to make it clear to the editorial office.

Authors who want a blind review should indicate this at the point of submission of their article, omitting details of authorship and other identifying information from the main manuscript. Submission for blind review is encouraged.

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Abbreviations where used must be standard. The Systeme International (SI) should be used for all units: where metric units are used the SI equivalent must also be given. Probability values and power statistics should be given with statistical values and degrees of freedom (e.g. $F(1,34) = 123.07$, $p < .001$), but such information may be included in tables rather than in the main text. Spelling must be consistent within an article, using either British spelling (*The Shorter Oxford English Dictionary*), or American (*Webster's New World College Dictionary*).

However, spelling in the list of references must be literal to each publication. Details of style not specified here may be determined by reference to the *Publication Manual of the American Psychological Association* or the style manual of the British Psychological Society.

Manuscripts should be double-spaced throughout allowing wide margins all round.

Where unpublished material e.g. behaviour rating scales or therapy manuals, are referred to in an article, copies should be submitted as an additional document (where copyright allows) to facilitate review.

MANUSCRIPTS SHOULD CONFORM TO THE FOLLOWING SCHEME

1. Title page.

The title should phrase concisely the major issues. Author(s) to be given with departmental affiliations and addresses, grouped appropriately. A running head of no more than 40 characters should be indicated, plus 4 keywords.

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a. Abstract. The abstract should be structured under the headings:

Background, Aims, Method, Results, Conclusions.

It should include up to six key words that could be used to describe the article. This should summarize the article in no more than 250 words.

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Kaltenthaler, E., Parry, G. and Beverley, C. (2004). Computerized cognitive behaviour therapy: a systematic review. *Behavioural and Cognitive Psychotherapy*, 32, 31–55.
doi:10.1017/S135246580400102X.

Tharp, R.G. and Wetzel, R.J. (1969). *Behaviour Modification in the Natural Environment*. New York: Academic Press.

Roskies, E. and Lazarus, R.S. (1980). Coping theory and the teaching of coping skills. In P.O. Davidson and S.M. Davidson (Eds.), *Behavioural Medicine: changing health lifestyles*. New York: Brunner/Mazel.

e. Footnotes. The first, and preferably only, footnote will appear at the foot of the first page of each article, and subsequently may acknowledge previous unpublished presentation (e.g. dissertation, meeting paper), financial support, scholarly or technical assistance, or a change in affiliation. A concluding (or only) paragraph must be the name and full mailing address of the author to whom enquires should be sent.

f. Required Sections

Acknowledgements

You may acknowledge individuals or organizations that provided advice, support (non-financial). Formal financial support and funding should be listed in the following section.

Ethical statements

All papers should include a statement indicating that authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the APA. Authors should also confirm if ethical approval was needed, by which organisation, and provide the relevant reference number. If no ethical approval was needed, the authors should state why.

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within the main text it is acceptable to replace identifiable information by using XXXXXX or similar.

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Tints and shading in figures may be used, but colour should be avoided unless essential. Although colour is possible in the online version, when designing a figure please ensure that any line variation/distinction demonstrated by colour can still be noted when in black and white. Colour figures are free of charge for online published articles but if authors wish figures to be published in colour in the print version the cost is £200. Numbered figure captions should be provided.

All artwork should be submitted as separate TIFF format files.

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Please see the following link for full guidance on artwork www.cambridge.org/core/services/authors/journals/journals-artwork-guide

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(Revised January 2017)

Appendix 2:

The Quality Assessment Tool for Studies with Diverse Designs

Item	Criteria	0 = Not at all	1 = Very slightly	2 = Moderately	3 = Complete
1	Explicit theoretical framework	No mention at all	Reference to broad theoretical basis	Reference to a specific theoretical basis	Explicit statement of theoretical framework and/or constructs applied to the research
2	Statement of aims/objectives in main body of report	No mention at all	General reference to aim/objective at some point in the report including abstract	Reference to broad aims/objectives in main body of report	Explicit statement of aims/objectives in main body of report
3	Clear description of research setting	No mention at all	General description of research area and background, e.g. 'in primary care'.	General description of research problem in the target population, e.g. 'among GPs in primary care'	Specific description of the research problem and target population in the context of the study, e.g. nurses and doctors from GP practices in the east midlands
4	Evidence of sample size considered in terms of analysis	No mention at all	Basic explanation for choice of sample size. Evidence that size of the sample has been considered in study design	Evidence of consideration of sample size in terms of saturation/information redundancy or to fit generic analytical requirements	Explicit statement of data being gathered until information redundancy/saturation was reached or to fit exact calculations for analytical requirements
5	Representative sample of target group of a reasonable size	No statement of target group	Sample is limited but represents some of the target group or representative but very small	Sample is somewhat diverse but not entirely representative, e.g. inclusive of all age groups, experience but only one workplace. Requires discussion of target population to determine what sample is required to be representative	Sample includes individuals to represent a cross section of the target population, considering factors such as experience, age and workplace

6	Description of procedure for data collection	No mention at all	Very basic and brief outline of data collection procedure, e.g. ‘using a questionnaire distributed to staff’.	States each stage of data collection procedure but with limited detail, or states some stages in details but omits others	Detailed description of each stage of the data collection procedure, including when, where and how data were gathered
7	Rationale for choice of data collection tool(s)	No mention at all.	Very limited explanation for choice of data collection tool(s).	Basic explanation of rationale for choice of data collection tool(s), e.g. based on use in a prior similar study	Detailed explanation of rationale for choice of data collection tool(s), e.g. relevance to the study aims and assessments of tool quality either statistically, e.g. for reliability & validity, or relevant qualitative assessment.
8	Detailed recruitment data	No mention at all.	Minimal recruitment data, e.g. no. of questionnaire sent and no. returned	Some recruitment information but not complete account of the recruitment process, e.g. recruitment figures but no information on strategy used.	Complete data regarding no. approached, no. recruited, attrition data where relevant, method of recruitment
9	Statistical assessment of reliability and validity of measurement tool(s) (Quantitative only)	No mention at all.	Reliability and validity of measurement tool(s) discussed, but not statistically assessed	Some attempt to assess reliability and validity of measurement tool(s) but insufficient, e.g. attempt to establish test–retest reliability is unsuccessful but no action is taken	Suitable and thorough statistical assessment of reliability and validity of measurement tool(s) with reference to the quality of evidence as a result of the measures used.
10	Fit between stated research question and method of data collection (Quantitative)	No research question stated.	Method of data collection can only address some aspects of the research question.	Method of data collection can address the research question but there is a more suitable alternative that could have been used or used in addition.	Method of data collection selected is the most suitable approach to attempt answer the research question
11	Fit between stated research question	No mention at all.	Structure and/or content only suitable to	Structure & content allows for data to be gathered broadly	Structure & content allows for detailed data to be gathered around all relevant

	and format and content of data collection tool e.g. interview schedule (Qualitative)		address the research question in some aspects or superficially.	addressing the stated research question(s) but could benefit from greater detail.	issues required to address the stated research question(s).
12	Fit between research question and method of analysis	No mention at all.	Method of analysis can only address the research question basically or broadly	Method of analysis can address the research question but there is a more suitable alternative that could have been used or used in addition to offer greater detail.	Method of analysis selected is the most suitable approach to attempt answer the research question in detail, e.g. for qualitative IPA preferable for experiences vs. content analysis to elicit frequency of occurrence of events, etc.
13	Good justification for analytical method selected	No mention at all.	Basic explanation for choice of analytical method	Fairly detailed explanation of choice of analytical method.	Detailed explanation for choice of analytical method based on nature of research question(s).
14	Assessment of reliability of analytical process (Qualitative only)	No mention at all.	More than one researcher involved in the analytical process but no further reliability assessment.	Limited attempt to assess reliability, e.g. reliance on one method.	Use of a range of methods to assess reliability, e.g. triangulation, multiple researchers, varying research backgrounds.
15	Evidence of user involvement in design	No mention at all	Use of pilot study but no involvement in planning stages of study design.	Pilot study with feedback from users informing changes to the design.	Explicit consultation with steering group or statement or formal consultation with users in planning of study design.
16	Strengths and limitations critically discussed	No mention at all.	Very limited mention of strengths and limitations with omissions of many key issues.	Discussion of some of the key strengths and weaknesses of the study but not complete.	Discussion of strengths and limitations of all aspects of study including design, measures, procedure, sample & analysis.

Appendix 3:

Quality Assessment rating scores of the reviewed papers.

Paper Reference Table

Paper Number	Author(s) and year of publication
1	Bennett-Levy and Beedie (2007).
2	Bennett-Levy and Lee (2014).
3	Bennett Levy, McManus, Westling and Fennell (2009).
4	Bennett Levy et al. (2015).
5	Chaddock, Thwaites, Bennet-Levy and Freeston (2014).
6	Foulkes (2003).
7	MacLiam (2015).
8	Owen-Pugh (2010).
9	Rakovshik and McManus (2013).
10	Rees, Krabbe and Monaghan (2009).
11	Schmidt and Foli-Andersen (2017).
12	Spafford and Haarhoff (2015).
13	Wolff and Auckenthaler (2014).

Quality Assessment Ratings

Criteria	Paper 1	Paper 2	Paper 3	Paper 4	Paper 5	Paper 6	Paper 7	Paper 8	Paper 9
1	3	2	3	0	3	0	1	3	1
2	3	3	3	3	3	2	3	3	3
3	3	3	3	3	3	2	3	3	3
4	3	2	0	2	3	1	3	3	3
5	2	3	3	3	1	3	3	2	2
6	3	3	3	3	3	1	3	3	3
7	2	3	1	3	2	1	3	3	3
8	3	2	3	3	3	1	3	2	3
9	2	NA	0	NA	1	0	0	NA	3
10	3	NA	3	NA	3	2	2	NA	3
11	2	3	NA	2	3	0	1	3	NA
12	3	3	3	3	3	0	2	3	3
13	3	3	3	3	2	0	1	2	3
14	3	3	NA	3	3	0	NA	0	NA
15	0	1	0	3	0	2	0	0	1
16	3	2	3	3	3	1	3	2	3
Total/ Percentage	41/48 85%	36/42 86%	31/42 74%	37/42 88%	39/48 81%	16/48 33%	31/45 69%	32/42 76%	37/42 88%
Rating	High	High	Moderate	High	High	Poor	Moderate	High	High

Quality Assessment Ratings Continued

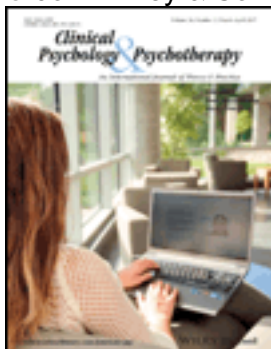
Criteria	Paper 10	Paper 11	Paper 12	Paper 13
1	1	1	3	3
2	3	3	3	3
3	3	3	3	3
4	1	3	3	3
5	2	3	2	3
6	3	2	3	3
7	2	2	2	3
8	1	2	3	2
9	0	1	NA	NA
10	2	3	NA	NA
11	2	NA	2	3
12	2	2	2	3
13	1	1	3	3
14	0	NA	1	3
15	1	3	0	0
16	1	2	2	2
Total / Percentage	25/48 52%	31/42 73%	32/42 76%	37/42 88%
Rating	Moderate	Moderate	High	High

Appendix 4:

Author guidelines for the Journal of Clinical Psychology and Psychotherapy

Clinical Psychology & Psychotherapy

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Edited By: Paul Emmelkamp and Mick Power

Impact Factor: 2.578

ISI Journal Citation Reports © Ranking: 2015: 29/122 (Psychology Clinical)

Online ISSN: 1099-0879

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- **Assessments:** Articles reporting useful information and data about new or existing measures.
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2. **If the author is named in the text, only the year is cited .**
Example: According to Irene Taylor (1990), the personalities of Charlotte. .
3. **If both the name of the author and the date are used in the text, parenthetical reference is not necessary.**
Example: In a 1989 article, Gould explains Darwin's most successful. . .
4. **Specific citations of pages or chapters follow the year .**
Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).
5. **When the reference is to a work by two authors, cite both names each time the reference appears .**
Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .
6. **When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al .* (meaning "and others") .**
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7. **When the reference is to a work by a corporate author, use the name of the organization as the author.**
Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).
8. **Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text .**
Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .
9. **Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows .**
Examples:
 - List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
 - Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
 - List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

Reference List

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References should be prepared according to the Publication Manual of the American Psychological Association (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Please note that a DOI should be provided for all references where available. For more information about APA referencing style, please refer to the

APA FAQ. Please note that for journal articles issue numbers are not included unless each in the volume begins with page one.

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, 159, 483–486.

doi:10.1176/appi.ajp.159.3.483.

Book edition

Bradley-Johnson, S. (1994). Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school (2nd ed.). Austin, TX: Pro-ed.

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Appendix 5:
Ethical approval

Ethics Feedback - EC.15.12.08.4403R2A
Psychethics

Mon 18/01/2016 10:14

To: Hannah Smith <SmithH28@cardiff.ac.uk>; Dougal Hare <HareD@cardiff.ac.uk>;

Dear Hannah,

The Ethics Committee has considered your revised amendment: Exploring CBT students' constructs of their personal and professional development (EC.15.12.08.4403R2A).

The project has now been approved.

Please note that if any changes are made to the above project then you must notify the Ethics Committee.

Best wishes,
Mark

Appendix 6:
Participant information sheet



PARTICIPANT INFORMATION SHEET

You are being invited to take part in a research study for a Clinical Psychology Doctorate thesis. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who will conduct the research?

Hannah Smith, Trainee Clinical Psychologist, School of Psychology, Cardiff University under the supervision of Dr Dougal Julian Hare.

What is the aim of the research?

The aim of the research is to explore how students undertaking their postgraduate diploma in Cognitive Behavioural Therapies (CBT) construe themselves and their professional development.

Why have I been chosen?

You have been chosen because you are a student undertaking the postgraduate diploma in CBT at Cardiff University, Everyone currently on the diploma have been asked if they would like to take part.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time, without giving a reason.

What would I be asked to do if I took part?

Once you have read the information sheet and have had the chance to ask questions, you will be asked to sign a consent form. The consent form will ask for your email address, and the researcher will contact you on this email address to arrange a convenient date and time for the first of two interviews. The first interview will be sometime in January/February 2016 and the second interview will be in September 2016. Both interviews will take exactly the same format.

Before the interview starts, the researcher will ask you to fill in a brief questionnaire on demographic details (age and gender), your core profession and when you qualified, the type of service you work in (e.g. Community Mental Health Team), and when and where you obtained your postgraduate certificate in CBT. This should take no more than five minutes. Your demographic details will be used to describe the group as a whole and will not be linked to the study data. The data will also be analysed as a whole group and no individual participant will be identified.

In the next stage, there will be a semi-structured interview during which you will fill in a repertory grid with the researcher. The researcher will use a digital audio recorder to record your conversation so that she can concentrate on the interview, rather than make notes. Immediately after the interview, the researcher will listen to this audio recording and make any notes on useful or interesting comments that were made. She will then delete the audio recording when the study finishes in May 2017. All your data will be identified by a participant number and no names or identifying details will be used. Only the researcher will have access to the key that identifies participants' numbers and names (which will only be used to match participants first and second interviews).

The repertory grid interview will require you to consider the following 11 individuals:

1. *Self before training (postgraduate certificate in CBT)*
2. *Actual (current) self*
3. *Self after training (Completing the postgraduate diploma in CBT)*
4. *Ideal self*
5. *A non CBT trained person doing your job*
6. *An ideal therapist*
7. *A compassionate therapist*
8. *A compassionate person*
9. *Someone you would turn to for help*
10. *Someone who is helpful in your team*
11. *A skilful therapist/helper*

You will be asked to think about how these individuals are similar and different. The researcher will randomly pick three individuals and ask you to say how two of them are alike and different from a third. For example, you might be given individuals 1, 2 and 3. You might say that 2 and 3 are alike because they are 'confident public speakers' whereas 1 is 'anxious about public speaking'. You will then have created a construct on which all 11 individuals can be rated from 1 = most anxious about public speaking to 5 = most confident about public speaking. This procedure will be repeated with a different set of 3 individuals, again and again until you have created at least 10 constructs and rated each of the 11 individuals on them. This will be your repertory grid and the researcher will invite you to check its accuracy.

As mentioned above, this study consists of two interviews, so after you have completed the first, the researcher will contact you in September to arrange a convenient time to repeat the interview. Once this is completed, you will be sent given a debrief form. If you decide to not to participate in the second interview, your debrief form will be emailed to you.

How will confidentiality be maintained?

All your data will be stored with a participant number only and any identifiable details that you give in your interview will be anonymised. Only the researcher (Hannah Smith), will have access to the document that lists participants' names so that the first and second interviews can be matched. All data will be transferred onto encrypted documents on university computers and paper copies will be destroyed. The data will be kept for five years and then destroyed. The data will be analysed for the whole group and thus individuals will not be identifiable.

What is the duration of the research?

The interview should take around 45-60 minutes. There will be two identical interviews – one in January/February 2016 and the second in October 2016. You will be contacted in October 2016 via email to arrange a convenient time for you to conduct the second interview.

Where will the research be conducted?

The interview will take place in a private room in the School of Psychology. Alternatively, if it is more convenient for you then I am able to come to your place of work to conduct the interview in a private room.

Will the outcomes of the research be published?

The research will be published and the findings presented at relevant professional conferences.

Who has reviewed the research project?

The project has been reviewed by Cardiff University's School of Psychology Ethics Committee.

What if something goes wrong?

If there are any issues regarding this research that you would prefer not to discuss with members of the research team, please contact the Ethics Committee administrator at:

Secretary to the Research Ethics Committee
School of Psychology
Tower Building
70 Park Place
Cardiff
CF10 3AT
Email: psychethics@cardiff.ac.uk

Who can I contact for further information?

Hannah Smith
(Trainee Clinical Psychologist)

Dr Dougal Julian Hare
(Research supervisor)

South Wales Doctoral Programme in
Clinical Psychology
School of Psychology
Cardiff University
Tower Building
Park Place
Cardiff
CF10 3AT

South Wales Doctoral Programme in
Clinical Psychology
School of Psychology
Cardiff University
Tower Building
Park Place
Cardiff
CF10 3AT

Email: SmithH28@cardiff.ac.uk

Email: HareD@cardiff.ac.uk

Thank you for considering taking part in this study.

Please take the time to ask any further questions. If you decide to take part in the study, you will be given a consent form to sign before arranging a time and place for your interview.

Appendix 7:
Consent form



CONSENT FORM

If you are happy to participate, please complete and sign the consent form below:

Please initial box

I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason.	
I give my permission for an audio recording of my interview and the use of anonymous quotes in publications.	
I would like to receive a summary of the findings from this study.	

I agree to take part in the above project conducted by Hannah Smith, School of Psychology, Cardiff University supervised by Dr Dougal Julian Hare:

Name of participant

Email address

Signature

Date

Appendix 8:
Demographic information questionnaire



Brief Demographic Questionnaire

Please complete the form below, prior to commencing the repertory grid:

Participant number	
Age	
Gender	
Core Profession	
Year in which core professional qualification was attained	
Service currently working in (e.g. Adult Community Mental Health Team)	
Institution awarding Postgraduate Certificate in CBT (e.g. Cardiff University)	
Year in which Postgraduate Certificate in CBT was awarded:	

Appendix 9:

Debrief form



DEBRIEF FORM

Thank you for participating in this study. The information you have provided in your interviews will be collated and analysed with the other interviews collected for this research. The findings from this study will enable us to understand how the current students on the postgraduate diploma in Cognitive Behavioural Therapies (CBT) construe themselves and their professional development with the aim of improving training and practice in CBT.

The consent form and the anonymous demographic information sheet that you completed will be kept in a locked filing cabinet in the Clinical Psychology Department at Cardiff University, only accessible by the researcher, Hannah Jenkins (nee Smith). The audio recording of your interview will be listened to immediately after the interview has concluded and then deleted. If you wish to have the group analysis and a summary of the findings once the study has been completed, please do not hesitate to contact us:

Hannah Jenkins (nee Smith)
(Trainee Clinical Psychologist)

Dr Dougal Julian Hare
(Research Director)

South Wales Doctoral Programme in
Clinical Psychology
School of Psychology
Cardiff University
Tower Building
Park Place
Cardiff
CF10 3AT

South Wales Doctoral Programme in
Clinical Psychology
School of Psychology
Cardiff University
Tower Building
Park Place
Cardiff
CF10 3AT

Email: SmithH28@cardiff.ac.uk

Email: HareD@cardiff.ac.uk

If there are any issues regarding this research that you would prefer not to discuss with members of the research team, please contact the Ethics Committee administrator at:

Secretary to the Research Ethics Committee
School of Psychology
Tower Building
70 Park Place
Cardiff
CF10 3AT

Email: psychethics@cardiff.ac.uk

Thank you again for your participation in this study.

Appendix 10:
Classification System for Personal Constructs

Construct Category	Description	Example
Moral	Constructs relating to the moral value of the element or person described.	Good – Bad Altruist – Egoist Humble - Proud
Emotional	Constructs relating to the degree of emotionality or sexuality of the element described, to his/her emotional attitude towards life or regarding specific feelings.	Visceral – Rational Warm – Cold Optimist - Pessimist
Relational	Constructs describing types of relationships with others, concentrating primarily on those limited to the scope of relationships.	Extroverted – Introverted Pleasant – Unpleasant Direct – Devious
Personal	Constructs relating to the variety of characteristics traditionally observed in the areas of personality, character, or way of being.	Strong – Weak Active – Passive Hard working - Lazy
Intellectual/Operational	Constructs referring to skills, abilities and knowledge and the intellectual and operational level.	Capable – Incapable Intelligent – Dull Cultured - Uncultured
Values and Interests	Constructs referring to ideological, religious or distinct values, as well as specific interests.	Ideological, political, religious, social, moral and gender values
Existential	Constructs relating to the assessment of central or existential projects or appraisals, often of the respondent's own core sense of life or self, relating to issues of meaning, purpose or direction.	Purposeful – Purposeless Growth – Stagnation Fulfilment - Emptiness
Concrete	Constructs that refer to concrete features or positions of people as well as their actions.	Physical characteristics Social roles Specific behaviours