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The relationship between model fidelity and therapeutic practice

Section A: Model fidelity in clinical practice: A Review of therapists'
experiences and attitudes towards model adherence

5496 words (+ 288 additional words)

Section B: A grounded theory of model fidelity in clinical psychologists'
therapeutic practice

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DEPARTMENT OF APPLIED PSYCHOLOGY
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DECLARATION FOR MAJOR RESEARCH PROJECT
Stefan Peart

DECLARATION

This work has not previously been accepted in substance for any degree and is not

being concurrently submitted in candidature for any degree.

Signed.. (candidate)

Date ....

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated.

Other sources are acknowledged by footnotes giving explicit references. A

bibliography is appended.

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STATEMENT 2

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Acknowledgements

Summary of MRP portfolio

Section A provides a review of empirical literature researching therapists' experiences, opinions and attitudes towards the practice of model fidelity. Sixteen studies are reviewed, synthesized and critiqued, and findings are categorised into themes. Results of the review suggest therapists' have complex relationships with model fidelity, shaped by multifaceted combinations of attitudes, values, personal, professional and skill development, clinical complexity, and experience. Findings are also considered in relation to pertinent theories. Clinical and research implications are discussed.

Section B presents a grounded theory of model fidelity in clinical psychologists' therapeutic practice. The theory was developed from semi-structured interviews conducted with 13 clinical psychologists with varying expertise. Through analysis, a hierarchy of categories emerged from the data, describing stages of therapeutic practice. The grounded theory suggests that clinical psychologists have evolving relationships with model fidelity, moving from model-centered practice to person-centered approaches with greater experience. Implications for clinical practice and research are discussed.

Section C provides a critical appraisal and reflections of the research experience, considering what skills have been learnt, what could have been done differently and how the research could be taken forward.

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Section A

Model fidelity in clinical practice: A Review of therapists' experiences and attitudes towards model adherence

Stefan Peart

Word count: 5496 (+ 288 additional words)

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Abstract

The aim of this review was to assess therapists' relationship with model fidelity. Empirical research examining therapists' experiences, opinions or attitudes towards the practice of model fidelity was synthesized and critiqued. Sixteen studies were reviewed. Findings inferred therapists have complex relationships with model fidelity, shaped by multifaceted combinations of attitudes, values, personal and professional development. Clinical flexibility and therapeutic alliance were generally more highly valued than model fidelity. When working with clinical complexity, therapists tended to deviate from highly-structured models (consciously and unconsciously), with some self-proclaimed, singular-model therapists objectively found to practice in eclectic or integrative manners. Theories alluding to the assimilation of spheres of knowledge in practice were explored. These theories inferred that model modifications may be inevitable as therapists adapt and assimilate information/skills into pre-existing practices. The review posed questions about the clinical applicability of fidelity to research-driven, diagnostic-based therapeutic models given the complex nature of psychological distress. Research to better understand properties and interrelationships between therapists and model fidelity were implicated. Further empirical focus to tease apart when and why fidelity may (or may not) be useful, to explore the feasibility of fidelity in practice as reported by clinicians, and to consider the function of diagnosis-driven interventions in psychotherapy were highlighted from this review.

Introduction

Desire for Evidence-Based Therapies (EBTs) in mental health arenas has amplified interest in model fidelity. Treatment efficacy trials prioritise fidelity to model frameworks to control for confounding variables on outcome. When an evidence-base builds, therapists are encouraged via dissemination to practice with fidelity to evidenced models (Mitchell, 2009). EBTs have sparked debate regarding the pros and cons of model fidelity in clinical practice. This literature review explored therapists' relationship with model fidelity—deemed imperative for understanding the utility of EBTs in healthcare settings (Aarons, 2004).

Treatment fidelity in psychotherapy and the department of health

Norcross (2005), discussing the nature of therapy, described therapeutic models as theoretical frameworks and clinical procedures that purport to explain and alleviate human distress. The degree therapists implement models in accordance with essential theoretic and procedural elements has been termed "model fidelity" — defined by McGrew et al. (1994) in their study of model implementation as conformity to prescribed model elements and absence of non-prescribed elements. However, a singular definition of fidelity has not been agreed upon; various terms are used to describe the same phenomenon (adherence, integrity, faithful implementation). In a review of fidelity implementation research, Dusenbury et al. (2003) found definitions of fidelity most commonly included components on:

- Adherence – whether interventions are delivered as designed.

- Competence - how well interventions are implemented.

- Program differentiation - distinctions in techniques and parameters.

Fidelity emerged in psychotherapy as a means to operationalise, define and refine therapeutic models (Bond et al., 2000). In research trials absence of fidelity can obscure conclusions

about a model's efficacy (Bond et al., 2000). Practice variation can be subtle in psychotherapy, so strict fidelity is important to reduce confounding variables and build a robust evidence base (Green & Latchford, 2012). Treatment manuals (TMs) were developed to ensure internal validity of research; they explicate principles and techniques of therapeutic models — things therapists should do to demonstrate fidelity and achieve optimal outcome (Green & Latchford). Therapists participating in research trials are monitored for fidelity (usually by audio or video recordings) and it is assumed that, should procedures described in manuals be adhered to, treatment effects will be optimised (Green & Latchford). Research has implications for clinical practice. Efficacious EBTs for psychological disorders described in diagnostic manuals are promoted for clinical use (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). In 2001, the UK's Department of Health, with support from psychotherapeutic organisations such as the British Psychological Society and the Royal College of Psychiatrists, published a guideline recommending EBTs for some mental health problems (Department of Health, 2001).

As dissemination of psychotherapeutic research matures, model fidelity looks set to remain a priority to treatment developers, program administrators and policymakers for the Department of Health, as the impetus for employing EBTs continues to gather momentum. For instance, the National Institute of Mental Health (2011) sanctioned an initiative supporting research to enhance community-based therapists' fidelity to EBTs for mental health disorders, while Roth and Piling (2007; 2008), in their identification of "core competencies" of therapists, focused specifically on the evidence-base of research trials. The Improving Access to Psychological Therapies (IAPT) programme, launched in 2007, provided the backdrop for development of competences for Cognitive-Behavioural Therapy

(CBT) which has the most evidence supporting treatment efficacy for anxiety and depression (NICE, 2005).

Research versus practice

Fidelity to empirically-supported, manual-based models has been associated with positive therapeutic outcomes in research (e.g. DeRubeis & Feeley, 1991; Schulte et al., 1992). Henggeler et al. (1997; 1999; 2003), while researching the utility of Multi-Systemic Model, found fidelity to EBTs essential for treatment gains and suggested that fidelity failure was responsible for reduced effect sizes seen between research and practice settings.

Dissemination of efficacious treatments to practising therapists is important to encourage fidelity to EBTs. However, whilst endorsers of EBTs would argue that empirically validated research should drive all clinical practice, research has shown few practitioners strictly adhere to models; furthermore, clients treated in community settings may not receive EBTs as intended by treatment developers (Addis & Krasnow, 2000; Carroll & Rounsaville, 2007; Herschell, 2010). Numerous reasons for non-adherence have been cited: Practical and financial restraints of the workplace and methodological requirements associated with systematic or controlled approaches to psychotherapy, to name a few (Addis, Wade & Hatgis, 1999). From a review considering what randomised controlled trials (RCTs) offer practitioners, Altman (2001) found practitioners do not always subscribe to EBTs because of disbelief in their validity and efficacy. This may be related to the often cited "research to practice gap", referring to proposed differences between research-based and practice-based therapies (Norcross, Klonsky & Tropiano, 2008). Critics of EBTs have argued that results gleaned from research trials are unrealisable in clinical practice. This is partly because individuals with complex difficulties and comorbidity are excluded from research trials, while in practice settings therapists frequently work with people who have complex

difficulties and needs, requiring multi-disciplinary interventions. Discussing the nature of clinical practice, Carlstedt (2009) has argued that clinical research is inherently flawed and that no absolutes regarding psychotherapy can ever be made by adopting intervention protocols because each client is complex and unique and other immeasurable variables influence an intervention's outcome. Furthermore, while fidelity monitoring in research is achievable via expert observation, this would be unfeasible in clinical settings due to monetary and professional demands. Even in research fidelity appears mainly to be assessed using self-report measures, with only marginal numbers attempting objective measurements. This has been a source of criticism with some researchers and professionals suggesting that self-report measures are prone to overestimations of both fidelity and competence (Perepletchikova, Treat, & Kazdin, 2007; Brosan, Reynolds & Moore, 2008).

Seligman (1995), critiquing a Consumer Reports' (1995) review of psychotherapy, opined that, unlike controlled research, clinical practice "is self-correcting. If one technique is not working, another technique—or even modality—is usually tried" (p. 967). Research (e.g. Freheit et al., 2004) has confirmed that in practice even 'pure form' therapies might be modified in ways that do not reflect the model the practitioner claims to be practising as therapists exercise judgment in relation to their sense of their clients' needs. Based on direct observations, Santa Ana et al. (2008) found only 5% of practitioners practiced CBT with adequate fidelity. Eclecticism (borrowing parts from therapeutic models as perceived necessary) and integration (theoretic fusion to create distinct models) might explain why because in recent decades therapists have moved away from identifying with singular theories and models towards integrative or eclectic therapeutic orientations (Norcross & Goldfried, 2005; Orlinsky & Ronnestad, 2005)

Debate on fidelity

Inspection of current literature revealed considerable debate on the role of model fidelity and EBTs in clinical practice. There were those advocating EBTs be paramount to clinicians' practice (e.g. Chambless & Hollon, 1998; Sanderson & Rego, 2000a; 2000b), and those loath to surrender therapeutic practice to what were deemed diagnostic-based, manualised, CBT models (e.g. Bohart, 2000; Levant, 2004). Further debate surrounded treatment manuals (TMs), which could be seen to counter traditional methods of conceptualizing the therapeutic process. Clinical judgment and tailoring treatments to clients' idiographic needs have long been thought indicative of a competent therapist; thus EBTs have been accused of promoting clinical inflexibility and adherence to single theoretical perspectives (Goldfried & Wolfe, 1998). Critics have accused EBTs of not considering clinical complexity or heterogeneity of clients (Goldfried & Wolfe, 1996); for impeding innovative clinical practice (Gaston & Gagnon, 1996); and for being too rigid (Wilson, 1996; 1998a; 1998b). Others have criticised EBTs for overemphasizing technique at expense of theory (Silverman, 1996), ignoring the role of the individual therapist (Garfield, 1998), relying on diagnostic categories that distract from complexities of life (Fensterheim & Raw, 1996) and undermining clinical judgment (Davison & Lazarus, 1995).

Advantages of manual-based EBTs (MEBTs) have also been offered. They have been praised for their utility in training and supervising therapists, for expediting clinical audit, bringing greater accountability to clinical psychology by standardizing therapies, and for helping to identify and clarify the nature of therapist effects. Wilson (1996; 1998a; 199b), endorsing the clinical application of research, branded it fallacy that clinical judgement, individualized care and comorbidity were precluded by MEBT fidelity. In Wilson's view, idiographic case formulations do not guarantee quality treatment because therapists can draw from hundreds

of theories or models to formulate and subjective judgement/bias impacts upon those selected, not necessarily what works from an evidential standpoint. Addressing the utility of MEBTs, Kendall et al. (1998) suggested that negative connotations towards manualised therapies were the biggest barrier to their implementation and that opinions were not experientially based. Kendall et al. believed opposition would lessen if therapists were encouraged to conceptualise MEBTs as theoretical frameworks offering practice guidance. Moreover, widespread mistrust of EBTs was disputed by Addis and Krasnow (1999). In their experience training therapists, pervasive negativity towards EBTs was uncommon and most clinicians embraced learning and implementing EBTs.

Review rationale and objectives

Preliminary searches into literature on model fidelity in psychotherapy unearthed extensive discussions about its worth, mostly from outspoken practitioners or researchers publishing opinions in journals about EBTs (e.g. Fensterheim & Raw, 1996; Strupp & Anderson, 1997). Less abundant was empirical research assessing therapists' attitudes towards model fidelity, yet it is therapists who use these models and decide how faithfully to implement them. Psychotherapeutic research has been criticised for placing too little value on clinicians' expertise and a need to combine science and practice wisdom was identified (Epstein, 2009). Therefore, this review will contemplate therapists' attitudes towards model fidelity, drawing on extant empirical literature to consider:

1) What therapists reveal about their relationship with model fidelity.

2) How findings can be understood theoretically.

3) What implications the findings have.

Methodology

Databases were searched to locate peer-reviewed, empirical research that assessed therapists' attitudes towards model fidelity (see Appendix 1 for search strategy and inclusion and exclusion criteria). Twelve quantitative studies, one mixed methodology and three qualitative studies (totalling 16) were identified (see appendix 2 for table of reviewed studies). The majority measured clinicians' attitudes towards EBTs. Three articles inspected relationships between attitudes to fidelity and clinical practice. Three articles assessed attitudes of integrative/eclectic therapists specifically, offering insight into why some psychologists do not practice singular model fidelity. Themes were developed broadly using inductive thematic analysis techniques as described by Braun & Clarke (2006). Recurrent patterns and important findings about therapists' relationship with model fidelity were identified in the studies, coded and categorised into broader themes based on similarities. This approach involved repetitive reading and comparison of the studies and the attributed codes to ascertain that the themes appropriately categorised and described the studies' findings.

Review Themes

Themes gleaned from the literature review will now be presented in order of coding frequency, with the most prevalent described first.

Research to practice

A relationship between attitudes towards research and EBT fidelity was observed in eight studies (Najavits et al., 2000; Freiheit et al., 2004; Nelson, Steele & Mize, 2006; Nelson & Steele, 2007; Nelson & Steele, 2008; Jensen-Doss, Hawley, Lopez & Ostenberg, 2009; Berke, Rozell, Hogan, Norcross & Karpiak, 2011; Gaudiano, Brown & Miller, 2011). Opinions were dichotomised with therapists either endorsing fidelity to EBTs because of research backing, or mistrustful of EBTs because of perceived incongruence between

research and practice. Therapists (88%) in Freiheit et al.'s (2004) study advocated fidelity to CBT for treating anxiety disorders because of research support. Najavits et al. (2000) studied therapists' attitudes towards EBTs and found 75% of CBT therapists used CBT manuals for intrinsic factors i.e. to improve therapeutic skills, broaden knowledge and to enhance clinical affectivity.

Comparatively, in Nelson, Steele and Mize's (2006) study, practitioners were generally sceptical about EBTs with concern expressed about the applicability of therapies tested in highly controlled research. Therapists suggested that dismissing the merits of non-empirically-based interventions may be counterproductive when the merits of many alternative treatments had not even been empirically studied. Therapists might therefore question why they should abandon experientially effective practices when they have not been proven ineffective in research, merely because other approaches have research-backing.

Complexity

Several studies suggested therapists' perceptions about client characteristics, such as complex and comorbid disorders, influenced attitudes and EBT use (Addis & Krasnow, 2000; Godley et al., 2001; Mullen & Bacon, 2006; Nelson, Steele, Mize, 2006; Aarons & Palinkas, 2007; Nelson & Steele, 2008; Jensen Doss et al., 2009). In Addis and Krasnow's national survey of attitudes towards MEBTs, clinicians were more likely to rate MEBTs inappropriate for complex presentations such as personality disorders. Whilst assessing experiences of children's mental-health workers using EBTs, Jensen-Doss et al. found clinicians tended to deviate from model protocol to intuitively meet clients' complex needs. Similarly, in Mullen and Bacon's study, psychologists who felt clients had complex needs were unlikely to practice with fidelity to EBTs. One psychologist commented, "I'm very much a believer in the complexity of development, individual difference, and the fact that the same

symptom/syndrome meant very different things in different people and thus required different interventions".

In Godley et al.'s (2001) study in which therapists were interviewed about MEBT-use with adolescents, restrictiveness was described by 58% of therapists adhering to differing models. Most frequently touted as restrictive was manualised CBT, but there was general worry across all models that clients' needs were not met when adhering to one model. For instance, therapists noted clients would have benefited from integration of family work with CBT but the model proscribed against this. Therapists generally felt "complexity" impacted upon MEBT-use and there was a perceived need to be more creative with "tougher" cases. Eighty percent of therapists delivering CBT and 100% of family therapists delivering Family Support Network (FSN) deviated from model protocol when faced with complex situations, i.e. when families were in crisis.

In Nelson, Steele and Mize's (2006) study, practitioners generally believed that research supporting EBTs was inapplicable to practice with children because "in real life people don't meet the [research's inclusion] criteria". One practitioner commented, "Our kids don't come in nice neat little packages. Most have multiple diagnoses". Other therapists suggested EBTs were rejected by their clients and sporadic attendance made adherence to structured protocols impossible. One therapist said, "so much of what I read is so inapplicable to what I actually do in terms of the level of complexity of cases, multiple diagnoses, and the parts of the therapy that can't be quantified."

Practice of fidelity
In Nelson, Steele and Mize's (2006) study, therapists reported preferences for using therapeutic interventions they were familiar with, even if these approaches were not backed

by research. Freiheit et al.'s (2004) study assessed fidelity to CBT for anxiety disorders among CBT oriented psychologists and found therapeutic approaches often did not conform to empirically supported CBT protocols, that disorder specific techniques affiliated to other models were used across CBT approaches for anxiety disorders, and that prescribed exposure-based interventions were rarely used despite strong empirical support. In Thoma and Cecero's (2009) study, therapists endorsed techniques outside their self-identified theoretic orientation. Psychodynamic, CBT and humanstic therapists used techniques that differed significantly from their respective orientations. Similarly, Berke et al. (2011) found many psychologists claimed to follow EBTs but their practice did not meet established criteria for efficacy.

This review indicated that, even when therapists think they are using models with fidelity, in practice they are not. Reasons why were unexplored but some hypotheses might include: a) Therapists not knowing what techniques were appropriate for specific models b) Similarities between model-specific techniques c) Experience with varying models, leading to unconscious amalgamations of singular models and model-specific techniques in practice. The latter infers that skill acquisition plays an important role in fidelity. The repertoire of therapists can be diverse and practice might illustrate this, with experienced therapists less inclined to follow theory-driven, evidenced prototypes.

Studies that examined views and practice of eclectic/integrative psychologists (Garfield & Kurtz, 1977; Norcross et al., 1988; Norcross et al., 2005) showed high proportions of psychologists switched to integrative or eclectic practice from singular model practice because no one model/theory was deemed adequate for handling client diversity. These psychologists were drawn to the wide range of techniques afforded by integration or

eclectism, choosing theory/technique dependent on what is best for each client. It may be that therapists in Freiheit et al. (2004) and Thoma and Cecero's (2009) studies (described above) deviated from preferential practice models for similar reasons as the self-identified integrationists.

Orientation

Berke et al. (2011) found psychologists' theoretical orientation predicted knowledge of research. Psychologists endorsing CBT reported greatest knowledge, followed by integrative/eclectic, psychoanalytic/psychodynamic, with humanistic/existential reporting least knowledge. Psychodynamic/analytic-oriented therapists showed significantly more negativity than CBT therapists towards MEBTs in Addis and Krasnow's (2001) study, although reasons why were unexplored and fidelity was not objectively measured. Two studies sampled therapists who predominantly practiced CBT (Najavits et al., 2001; Freiheit et al., 2004); these therapists were generally positive towards MEBT fidelity. There were also significant differences between theoretic orientation in self-reported EBT-use in Nelson and Steele's (2007; 2008) studies, which evaluated reasons why practitioners choose treatments. CBT-oriented therapists reported greater EBT-use and were more likely to be positively influenced by research (controlled and applied) than practitioners identifying with other theoretical orientations (psychodynamic, systemic). As EBTs and TMs evolved primarily from research on CBT outcomes, it is perhaps unsurprising that CBT-orientated therapists were more likely to endorse their use.

Clinical experience

Clinical experience was a theme common to several studies. Berke et al. (2011) assessed psychologists' knowledge of research methods central to EBT implementation and found clinical experience predicted knowledge of research: The less clinical experience, the higher the EBT-use. Addis and Krasnow's (2001) national survey found psychologists who had

practiced fewer years held more favourable attitudes towards MEBTs. Aarons (2004) examined attitudes towards EBTs in relation to individual and organizational characteristics and found greater clinical experience was associated with more critical attitudes towards EBT fidelity. There was an association found between clinicians' attitudes to EBTs and education level in Jensen-Doss et al.'s (2009) study. Those with undergraduate degrees held more positive attitudes than postgraduate or doctoral educated clinicians. Similarly, in Aarons and Palinkas' (2007) study, less experienced practitioners appreciated greater structure and model fidelity.

Based on these findings it could be hypothesised that experience mediates practice of model fidelity. Experienced clinicians who have accrued more practical knowledge of varying therapies might struggle more with strict fidelity than therapists with less experience to draw from.

Autonomy/flexibility/intuition
Generally, the more structured models were deemed inflexible and tended to garner most criticism from therapists. Therapists valued creativity, flexibility and adapting therapeutic techniques to fit with clients' needs over adherence to empirically-supported model protocols. In Addis and Krasnow's (2001) study, therapists holding negative views towards MEBTs tended to believe they dehumanized the therapeutic process and emphasized technique at expense of flexibility, therapeutic alliance, quality care and professional autonomy.

Psychologists in Mullen and Bacon's (2006) study believed MEBTs constrained judgement, autonomy and the therapeutic process. Comments included, "I am mistrustful of guidelines that seem to [...] exclude patient/clinician from decision making" or "I don't like following a formula if it doesn't feel right for the patient". This view appeared to be shared by therapists

treating adolescents in Godley et al.'s (2001) study, with "restrictive" being a theme gleaned from reports on MEBT use (Motivational interviewing, CBT, Multidimensional family therapy etc.). Therapists made reference to feeling stilted/stunted in therapeutic style or lacking freedom to "go with the flow". One therapist commented, "Doing therapy with a manual is more constraining in having to only stick with interventions that are prescribed".

For some therapists in Nelson, Steele and Mize's (2006) study, allowance of clinical creativity when using EBTs was related to positive attitudes towards the model. Therapists endorsed MEBTs if creativity, personalized/individualised treatment was encouraged by the model. Comments included, "[The model/manual] gives basic elements and then allows the clinician to use their own skill, in terms of exactly how it's communicated" or "There's enough allowance for [. . .] taking the individuality of each of the participants into the style of which a given coping skill is taught" or "It wasn't so rigid that it didn't allow for the ability to be creative" or "It provides the framework or philosophy in which to deal with the client, but it doesn't restrict you in the flexibility to meet an individual kid's or family's needs; you can still deliver unique treatment."

Therapeutic relationship

The therapeutic relationship was relevant to therapists' desire to be model adherent (Addis & Krasnow, 2001; Aarons & Palinkas, 2007). Therapists were willing to sacrifice model fidelity for the sake of maintaining rapport with clients and preserving therapeutic alliance in Aarons and Palinkas' study (a qualitative evaluation of EBT implementation in a children's service). Nelson, Steele and Mize (2006) found therapists viewed relational aspects of interventions with children more important than all other mechanisms of change, including model fidelity. One therapist commented, "You have to build a relationship before [children] will listen to anything you say that might be evidence-based".

Clinical judgement

Clinical judgement arose as a theme (Godley et al., 2001; Nelson, Steele, Mize, 2006; Gaudiano, Brown, Miller, 2011), suggesting this plays a role in clinicians' model fidelity. Guadino et al. (2011) found that intuitive thinking was associated with various dimensions of attitudes towards fidelity to EBTs, such as unwillingness to comply with requirements to use EBTs and increased use of non-empirically supported therapies. Intuition/clinical judgement may impact upon clinicians' tendency to be model adherent.

Formulation

Some studies suggested fidelity may be related to therapists' formulation preferences. Addressing "unique needs of clients" was considered important for therapists using MEBTs in Godley et al.'s (2001) study, with therapists endorsing or opposing models based on perceived allowances for individual case conceptualisation. In Addis and Krasnow's (2001) national US-based survey, psychologists were more positive towards MEBTs if individual case-conceptualization was emphasised by models, suggesting therapists favoured using idiosyncratic formulation over specific/generic models to understand human distress — arguably compatible to integrative or eclectic practices.

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Critique of studies

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To better consider the studies' methodologies, qualitative and quantitative studies were collectively critiqued.

Quantitative

Quantitative methodologies were considered in line with Cook and Campbell (1979) and Russell, Crimmings and Lent's (1984) criteria for methodological threats to validity, which consider internal, construct, and external validity threats.

A criticism of the quantitative methodologies was that statistical measurements were not enriched by participants' explanations, limiting interpretations. For instance, although studies suggested therapists valued clinical flexibility, they were not asked to elaborate upon what a flexible approach looked like. Mixed research methodologies could have remedied this.

All studies were US-based with mostly diminutive samples, limiting generalisability. It cannot be known to what extent therapeutic communities differ in other geographical locations. There was an over-representation of CBT-oriented therapists and participants were predominantly Caucasian females limiting generalisability to males, ethnic minorities and those oriented to other theories/models.

Issues regarding measurement were noted: All relied on self-report measures, prone to response distortion, method variance and mono-method bias (Razavi, 2001). No study attempted objective measurement and only two studies used a validated scale (Aarons, 2004; Guadiano et al., 2011). The others used un-validated/non-standardised scales, making it difficult to confirm they assessed what the researchers intended.

Demand characteristics may have impacted results. Mental health services are increasingly endorsing EBT-use so practitioners might have felt pressured to report increased use. The sampling (opportunity/snowball) and recruitment techniques (incentive/advertisements) could have threatened internal validity, only attracting a certain type of respondent i.e. those strongly opposing or endorsing a model.

Lastly, only two studies evaluated the relationship between therapists' attitudes and practice (Freiheit et al, 2004; Thoma & Cecero, 2009). Process/outcome data may have offered a more objective means of investigating practice of fidelity.

Qualitative

Qualitative methodologies were scrutinised using Yardley's (2000) criteria: 'Sensitivity to context', 'commitment and rigour', 'transparency and coherence' and 'impact and importance'. The four studies offered clear research rationales but varied in specificity of analysis reported. It was largely unclear the degree researchers engaged in immersion and crystilisation techniques. Positively, reliability was enhanced by inter-rater reliability and processes of theme identification were adequately documented in three of four studies (exception, Mullen & Bacon, 2006).

All studies offered little consideration to interviewers/researchers' influence on participants (reflexivity), nor were power imbalances considered. Researchers enquired about clinical practice, which might have inhibited truthful responses. Nelson, Steele and Mize's (2006) study, which used focus groups, was particularly susceptible to influences from group demand characteristics. Furthermore, whilst all studies added to knowledge about clinical practice, none adequately considered theoretical implications.

The qualitative methodologies provided rich/descriptive interpretations but as all were US-based they may not be applicable to practitioners working in the UK. In the reviewed studies, data saturation (a point where no new information would arise from further sampling; Paraboo, 2006) may not have occurred due to the small samples. Transferability, confirmability and credibility could have been enhanced had researchers described or interpreted their personal experiences using their chosen methodologies; outlined how/why

coding decisions were made; or asked participants to scrutinize findings to assess accuracy (Kocht, 2006).

Situating results theoretically

Based on the review's findings, several theories potentially relevant to model fidelity were identified.

Diffusion of innovation theory

Diffusion of innovation theory (Rogers, 2003) was considered relevant as it emphasises compatibility between new practices with existing practices. According to this theory, therapists evaluate new practices for compatibility with current practice to decide whether learning/using the new practice will be advantageous; this either facilitates or impedes adoption. Therapists likely adopt/integrate therapeutic models into practice if they are deemed compatible or complementary to current approaches. According to this model, treatment modifications are, therefore, inevitable. Offering support to this theory, Aarons and Palinkas (2007) found therapists' initial reluctance to implement new EBTs was overcome when they realised the EBT offered structure to existing practice.

Werner's Organismic theory

Werner's (1948; Werner & Kaplan, 1963) organismic-developmental theory may be pertinent to understanding therapeutic practice as it supports the process of complex skill integration. Werner saw development in terms of an organism-environmental relationship, marked by intrafunctional and interfunctional organization, whereby primitive "action systems" (person-in-environment systems) fuse with experiential and emotional stimuli, resulting in evolution and articulation of a system's components, which become more abstract/complex as one develops or gains experience. Werner theorised that humans' mental organisation for "action systems" proceeds from structurally undifferentiated (global) and functionally unrelated

states, towards the emergence of action systems that become more differentiated, integrated, complex and consolidated over time, resulting in new ways of thinking, greater flexibility, skill, knowledge (of self, others and the world) and specification. Advanced, differentiated action systems hierarchically integrate/assimilate the less developed undifferentiated systems.

When considered in relation to therapeutic practice and model fidelity, Werner's theory would suggest that with experience differentiation of the therapeutic process and the models that they use would occur for clinicians, granting developed understanding of what works for whom, when, and why and an ability to practise more flexibly, skilfully and integratively. Therapists with experience of multiple models would thus be able to (and predisposed to) hierarchically integrate and selectively incorporate skill/action components (technique and theory) from models (once perceptively separate) as necessary, to create broader integrated frameworks of therapeutic practice, distinct but nevertheless related to the models from which they originated. Each psychotherapy theory/model in its purest form tends to emphasize change processes above others rather than focus on multiple parallel change processes. However, practicing integrationists make on-going use of multiple change processes via theoretical integration, common factors approaches, assimilative integration and technical eclectism (Norcross, 2005), suggesting an ability to differentiate between, assimilate and integrate model-specific skill and theory in practice. Model integration may not be conscious either; Thoma and Cecero (2009) found that even self-proclaimed pure-form psychologists displayed two kinds of integration in practice, 'common factors' and 'assimilative integration'.

Practitioner's espoused theory
Schon's (1983; 1987) espoused theory may be relevant to model fidelity. According to this theory, when effective practitioners face difficulties during practice they instinctively draw

upon prior experience to problem-solve. Schon believed this reflective activity caused integration of prior knowledge with current experience, creating something "new". This theory highlights the importance of practical experience and reflective practice on learning, inferring that, far from following formal theories, practitioners construct their own theories of psychotherapy to adhere to. This could explain why therapists most commonly associate with eclectic or integrative practices.

Implicit theory

Therapists of the same theoretic-orientation can differ greatly in therapeutic practice (Luborsky et al., 1986; Najavits & Strupp, 1994), while therapists from differing theoretical orientations can be alike in therapeutic practice (Smith, Glass, & Miller, 1980). Implicit theory (Burrell, 1987; Kottler, 1986; Schon, 1983), referring to therapists' conscious, preconscious, or unconscious tacit assumptions about how to conduct psychotherapy, might offer an explanation for such incongruence. Implicit theories are distinct from but coexisting with explicit theoretic orientation (Najavits, 1997). Shoben (1962) believed therapists' implicit theories were personal traits composed of both explicit theoretical and implicit assumptions about therapy that develop because explicit (formal) theories were deemed insufficient, too abstract, impractical, or that they contradicted experiences (Sandler, 1983). Implicit theory implies therapists (often unconsciously) modify theories/models due to these limitations, borrowing from other theories/models or creating new theories/models.

Implicit theory infers that fidelity to one model would be challenging for therapists; text-book theories may be deemed insufficient to explain complexities of clients and therapeutic processes. Implicit theory may explain why some therapists (see Freiheit et al., 2004; Thoma & Cecero, 2009) showed incongruence between their expressed (explicit) CBT-orientation and clinical practice (observed to be integrative or eclectic). Therapists may have been

unconsciously modifying their practice due to the presence of implicit theories, developed in response to limitations of singular-model therapies.

Discussion

This review found therapists' relationship with clinical practice to be complex and shaped by multifaceted combinations of attitudes, values and development, as well as clients' needs (e.g. Godley et al., 2001; Aarons, 2004; Aarons & Palinkas, 2007). Rather than practising with fidelity, therapists appeared to integrate overlapping spheres of knowledge.

Therapists seemed least drawn to highly structured MEBTs, because they were deemed inflexible or to not meet clients' needs (Godley et al., 2001; Aarons & Palinkas, 2004). This finding suggested that therapists who valued person-centred, individualised therapeutic approaches were less receptive to strict model fidelity. Miller and Duncan (2000) have advocated for the wide-scale adoption of person-centred approaches over model-driven approaches in psychotherapy, backed by their finding that common factors to all therapeutic models (e.g. therapeutic alliance) account for 85% of variance in treatment outcomes, and further progress is purportedly dependent upon client acceptance, not therapeutic model.

Impediment of the therapeutic alliance was cited as an argument against strict fidelity in this review, and research supports the importance of this process variable over model fidelity (e.g. Raue et al., 1997; Rodd & Stewart, 2009). Indeed, Luborsky et al.'s (1975; 2002) meta-analyses of psychotherapy outcomes showed that, when correcting for the therapeutic alliance, no significant differences between models were calculated. Luborsky et al. used this data to support the proposition that psychotherapeutic models are equally effective (known as the "dodo bird verdict").

The current review suggested that therapists who prioritised the therapeutic alliance felt it unnecessary to privilege a model's framework exclusively, as the alliance's infrastructure supported a range of practices; however, the meta-relationship between therapeutic alliance and practice was insufficiently explored in the reviewed literature meaning firm conclusions cannot be made.

Experience was seemingly related to therapeutic practice, with more experienced therapists less likely to practise model fidelity. According to Yalom (1989), psychotherapy theories were developed to reduce therapist anxiety about dealing with complexity/uncertainty of therapeutic processes; it seems logical, therefore, that inexperienced practitioners might value model fidelity more. Alternatively, Westen et al. (2004) conceptualised clinical experience as a form of operant conditioning, whereby client contact improves clinical skills. Research has supported this, with therapists citing client contact as the most influential factor on their practise, above theory, research, supervision, or training (Orlinsky & Ronnestad, 2005). While the current review confirmed the presence of a link between experience and practise of fidelity, more research is necessary to understand what mediates this.

Two studies in this review found that therapists who believed they were practicing with fidelity were actually practising eclectically (Najivits et al., 2000; Freiheit et al., 2004). Other studies have shown that, even when required to practise with fidelity, therapists deviated from model protocol. Furthermore, some therapists never (or rarely) used EBTs despite being aware of empirical support (Nelson, Steele, Mize, 2006; Jensen-Doss et al., 2009). These findings pose questions regarding the applicability of model fidelity, such as 'is it ever truly possible to practise with fidelity to one model' and 'why might model fidelity be challenging

for practitioners?' The review identified several theories alluding to processes of assimilation of spheres of knowledge in practise. They inferred that modification of models may be inevitable as therapists adapt and assimilate information/skills into pre-existing knowledge/practise, creating personalised, integrative approaches. However, the literature offered insufficient evidence to back theories.

Implications

Clinical

As EBTs continue to imbed in mental health services, model fidelity will have implications for functions carried out by clinical psychologists. Due to training that combines science with practice, clinical psychologists are positioned within mental health organisations to practise, manage, supervise, disseminate and monitor fidelity (Chorpita, 2003). However, this review highlighted that practise of model fidelity is a scantily understood phenomenon. Expectation for clinicians to practise with fidelity to EBTs might merit closer inspection if, as implied, model modifications may be inherent to practise.

EBTs were developed in response to the rise of diagnosis in mental health (Green & Latchford, 2012), but this review highlighted that clinicians can struggle to categorise human complexity based on frequently overlapping and changing diagnostic criteria (e.g. depression and anxiety were not diagnostically separate until DSM-II, 1968). This raises pertinent questions about the appropriateness of fidelity to diagnostic-driven models in psychotherapy.

Research

This review suggested intrinsic factors impact upon therapists' practise, supporting the importance of studying clinicians' attitudes towards fidelity. Nevertheless, diminutive research evidencing theoretical or relational aspects of model fidelity was found. Critics of

EBTs have argued that researchers place too little value on attitudes and expertise of clinicians (Epstein, 2009), highlighting a need for research focusing on practice wisdom to understand adaptations of interventions and "what works for whom under what conditions" (Chorpita & Daleiden, 2009).

Observing how clinicians apply/adapt practise may also help identify similarities between models and support the development of integrated treatment models (Chorpita et al., 2005). As psychotherapy research moves towards identifying principles of therapeutic change (Castonguay & Beutler, 2005), researchers might benefit from understanding model integration and concomitant change processes, understood from therapists' experiences.

Given the complexities involved in therapeutic decision-making, pertinent questions regarding the importance of research in psychotherapy remain. RCTs, seen as a "gold-standard" of research, may be appropriate for medical science, but adaptations have been necessary to fit psychotherapy trials into RCT models (i.e. using protocols, sampling participants with singular diagnosis, and using scientnifically-measurable outcomes). This review suggested that psychological suffering might be unquantifiable at times, and that humans are more complex than the sum of their diagnoses. Given that clinicians tended to deviate from model protocols when faced with clinical complexity, reconsideration of how therapy is researched may be necessary (e.g. using more formulation or practise-based research-methods that attempt to qualitatively understand therapists' experiences).

Conclusions

Currently, little is known about how psychotherapies are implemented (Carroll & Rounsaville, 2007). More research is needed to understand the intricacies of therapeutic

processes—why and how therapists use models. The review posed questions about the applicability of model fidelity, e.g. is it possible for therapists to adhere to one model and how instinctive is integration given the complex nature of human distress?

Research to better understand properties and interrelationships between therapists and model fidelity is warranted to tease apart idiosyncracities about when and why fidelity may (may not) be useful, to understand the feasibility of fidelity in practice, and to consider the function of diagnosis-driven interventions in psychotherapy.

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Section B

A grounded theory of model fidelity in clinical psychologists' therapeutic practice

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Abstract

Important in the practise of evidence-based therapies (EBTs), model fidelity is thought to be crucial in order to replicate efficacious findings gleaned from research trials assessing therapeutic interventions. Clinical psychologists' training emphasises research-based practice and, uniquely in mental health settings, they are also trained to use varying models. Research shows psychologists may adapt and combine these models for a range of reasons and surveys suggest orientation to integrative and eclectic practise of therapy have surpassed singular-model fidelity, suggesting potential non-adherence to EBTs despite their training emphasising research-based practise. As much remains unknown about clinical psychologists' therapeutic practice, this study presents a grounded theory and working model of (N=13) clinical psychologists' relationship with model fidelity. The study considers how and why models are used, what psychologists adhere to in practice, and how experience and expertise mediate model-use. Through analysis, a hierarchy of categories emerged from the data describing stages of therapeutic practice. The grounded theory suggests clinical psychologists' have evolving relationships with model fidelity. Practice was shown to be driven by desires to meet needs of those treated therapeutically. Approaches to achieve this altered with experience. Psychologists reflected upon tendencies towards model-centered practice when clinically inexperienced, but evolved to more person-centered approaches due to several impacting factors. The evolutionary process elicited a more critical/reflective stance towards model-use and ambivalence towards the role of research-based models in practice. This might be seen to corroborate the often-referenced "research to practice gap" and implies more research on practice-based wisdom to understand therapeutic processes could be beneficial.

Introduction

Mental health services are increasingly expected to offer evidenced-based therapies (EBTs; Department of Health, 2001). In 2011, the National Institute of Mental Health sanctioned an initiative supporting research to enhance community-based therapists' adherence to EBTs. Model fidelity—the degree therapists implement treatment models as prescribed by developers— has an important role in psychotherapy efficacy research, results of which disseminate to clinical practice (Green & Latchford, 2012). Model fidelity is deemed beneficial for understanding how therapies can be improved, why therapies succeed/fail, what impacts upon outcome, and to reduce confounding variables. There is an assumption that, should clinicians practice with fidelity to evidence-based models, outcome will be optimized (Green & Latchford).

Nonetheless uptake of EBTs at professional levels has been slow; a general reticence for therapists to practise with model fidelity has been observed (Michie et al., 2005). With concern to mental health interventions, research shows treatment modifications are more likely to occur than not (Larsen & Agarwala-Rogers, 1977). Therapists have shown mistrust in research-based findings, believing them ungeneralisable to clinical practice (Altman, 2001)—a paradigm known as the "research-to-practice-gap" (Norcross, Klonsky & Tropiano, 2008). Participants in efficacy trials may be deemed unrepresentative of practice-based clients because sampling in randomised controlled trials (RCTs; deemed the "gold standard" of research) is not inclusive—comorbidity and clinical complexity (multifaceted factors that contribute to and maintain difficulties) may be vastly underrepresented (Westen, Novotny & Thompson-Brenner, 2004). Critics of RCTs argue that they rarely focus beyond amelioration of singular disorders, and there is little consideration for complexity beyond diagnostic categories. However in practice-settings clinical complexity is highly prevalent (Mitchell,

2011). Emotional and behavioural problems may be interconnected with socioeconomic problems, learning difficulties, cultural factors, social isolation, relational dynamics, illness, identity factors, employment status, education, substance abuse, risk, and multi-agency input, to form complex and layered systems over cross-sectional and longitudinal contexts (Hawley & Weisz, 2002).

When working with complexity clinicians may deviate from models and practise intuitively, flexibly and creatively out of perceived necessity (Godley et al., 2001; Nelson & Steele, 2008).Therapists valuing person-centred, individualised care may be even less receptive to model fidelity (Aarons & Palinkas, 2007). In a study exploring therapists' attitudes towards EBTs, Godley et al. found some therapists advocated for model integration when faced with complexity because using one model was deemed insufficient to meet clients' needs. For some practitioners, overlapping spheres of knowledge via technical eclectism (borrowing parts from models as necessary) or model integration (theoretic fusion to create distinct models) may be both valued and deemed necessary when working with complexity, due to perceived limitations of singular model practice.

Practice surveys show more therapists practise eclecticically or integratively than with fidelity to one model (Norcross & Goldfried, 2005; Orlinsky & Ronnestad, 2005). Therapists may deliberately abstain from adherence: Studies have found therapists deviated from model protocols even when required to practise with fidelity, while some therapists never (or rarely) used EBTs despite being aware of empirical support (Nelson, Steele, Mize, 2006; Jensen-Doss et al., 2009). Therapists may also be unaware of model adaptations. Santa Ana et al. (2008) found only 5% of practitioners practised Cognitive Behavioural Therapy (CBT) with adequate fidelity, while Thoma and Cecero (2009) found psychodynamic, CBT and humanstic therapists frequently endorsed techniques outside their self-identified orientations.

Similarly, Berke et al. (2011) found many psychologists claimed to follow EBT models but their practice did not meet efficacy criteria. Theories such as the diffusion of innovation theory (Rogers, 2003), Werner's (1948) organismic-developmental theory, Schon's (1987) espoused theory and implicit theory (Burrell, 1987) have alluded to processes of assimilation of knowledge in practice by means of development, skill-acquisition and experience. Theories such as these infer model modifications are inevitable as therapists adapt and assimilate information or skills into pre-existing practice, creating personalised, integrative approaches. Repertoires can be diverse and more experienced therapists may be less inclined to follow theory-driven, evidenced prototypes (Aarons, 2004). However, evidence found to back these theories was minimal.

Study rationale

Given the complexities involved in therapeutic processes, questions regarding the applicability and feasibility of model fidelity have been posed, such as "if therapists are not adhering to models during therapy, what are they adhering to?" This may be particularly pertinent to ask of clinical psychologists who by nature of training are exposed to numerous therapeutic models. Research confirms therapists' relationship with practice is complex and may be shaped by multifaceted combinations of attitudes, values and development (Godley et al., 2001; Aarons, 2004; Aarons & Palinkas, 2007); however, diminutive research evidencing theoretical or relational aspects of therapists' model fidelity was found. Little is known about how psychotherapies are implemented or how therapists value and adhere to models (Carroll & Rounsaville, 2007). Furthermore, there is a paucity of empirical research exploring clinicians' practice wisdom (Epstein, 2009). Given the prominence of fidelity to EBTs in mainstream therapeutic practice, a need has been highlighted for more empirical focus on practice wisdom to understand intervention adaptations (Chorpita & Daleiden, 2009).

Aims

This research aimed to consider the applicability of model fidelity for clinical psychologists, to explore what psychologists are adhering to in practice, and the relationship between fidelity, skill acquisition and expertise.

Method

Participants

Thirteen Clinical psychologists were recruited. Some practised more prominently in one model than others, but all were trained to use multiple models as part of their doctorate qualification. The majority identified their therapeutic orientation as "integrative".

Table 1. Participant data

Participant	Gender	Age	Years qualified	Job title	Specialty	Therapeutic orientation
Veronica	Female	52	22	Consultant Clinical Psychologist	Older adults	"Psychodynamic and systemic"
Gillian	Female	32	6	Clinical Psychologist	Crisis intervention	"Integrative"
Sue	Female	29	3	Clinical psychologist	Learning disability/Forensic	"Integrative with a preference for CBT"
Graham	Male	33	5	Clinical Psychologist	Adult secondary care	"Integrative with a preference for CBT"
Louise	Female	36	12	Clinical psychologist	Adult primary care	"Integrative with a preference for CBT"
Elaine	Female	53	30	Consultant clinical psychologist	Neuro-developmental	"Integrative"
Tammy	Female	38	10	Clinical psychologist	Older adults/memory clinic	"Integrative"
Coral	Female	32	2	Clinical psychologist	Child and adolescent	"Integrative with a preference for psychodynamic"

Stephanie	Female	30	4	Clinical psychologist	Looked after children	"Integrative"
Sonia	Female	43	16	Chartered clinical psychologist	Adult	"Integrative"
Melanie	Female	34	5	Clinical psychologist	Early intervention	"Integrative with systemic base"
Julie	Female	33	7	Clinical psychologist	Drug and alcohol team	"Integrative with CBT foundation"
Drew	Male	42	10	Principle Clinical psychologist	Adolescents	"Integrative"

Design

This exploratory, qualitative study used semi-structured interviewing with open-ended questions relevant to the research topic (see appendix 3). This method was selected over quantitative methods as the study explored experiential practices as understood by practitioners.

To enhance content validity, two independent practising clinical psychologists (known to the researcher) were asked to review the interview structure. As a result of consensus it was decided that there was repetition or overlap in three of the original questions about the practise of model fidelity; these were subsequently merged into one question. The interview consisted of exploratory questions about model-use, fidelity, times when it is useful/not useful, what psychologists are adhering to, the role of research in clinical psychology and what affects practice. Semi-structured interviews allowed two-way conversation between researcher and participants, enabling the researcher to follow-up on interesting threads in dialogue. This process proffered rich data essential for qualitative analysis, whilst still enabling the researcher to guide content.

Procedure

Self-selection, opportunity and snowball sampling methods were used to recruit a broad range of psychologists from varying specialities. Psychologists were approached by person, phone or email using a NHS trust's practitioner directory with Research and Development (R&D) consent (appendix 4). Anonymity was discussed and practitioners were given a consent form and study information sheet (appendix 5, 6). Interviews were conducted between September 2011 and February 2013. Participants were informed they could terminate interviews/withdraw at any point. Interviews (approximately 35-40 minutes) were digitally recorded, transcribed verbatim and anonymised. Recruitment ended when theoretical saturation occurred. Saturation was gauged when no new categories or properties emerged from the data. By the thirteenth interview it became evident that new data only corroborated findings from subsequent interviews, indicating saturation. According to Strauss & Corbin (1998), saturation makes further data gathering unnecessary because at this point it should be possible to abstract a formal theory from findings.

Analysis

Grounded Theory (GT) according to Strauss and Corbin (1998) was used. This approach takes both constructionist and relativist ontological positions and enabled rich, reflective analysis and theory construction related to context. It is classified as interpretive but acknowledges the multiplicity of perspectives/truths of those studied (Strauss & Corbin, 1998). GT is deemed useful for exploring under-researched phenomena, attitudes, experiences and behaviours of distinct samples (Strauss & Corbin, 1998). Analysis followed three stages:

- Open coding: Breaking down, examining, comparing, conceptualizing, and categorizing data. For example, a quotation in the text that read "If one is newer to

psychological therapies, it is probably safer for the client if the therapist adheres to a protocol" was broken down to ascertain the meaning behind what the interviewee said or what they were doing with the language they used. In this instance the open code assigned to this quote was "model fidelity is being used as a safety net".

- Axial coding: connecting categories and using a coding paradigm involving conditions, context, action/interactional strategies and consequences to identify central phenomenon. This process required comparisons of the open coding to identify links and interactions. For example, this study found that certain open codes i.e. "Anxiety reducing" and "model fidelity is being used as a safety net", were connected in that they both related to a sense of "containment" of anxiety, which became an axial code.

- Selective coding: Selecting a core category, systematically relating it to other categories, validating category relationships, and refinement. Comparisons of groups of axial codes were further subdivided based on connections and inter-relationships to form broader categories. For instance, two of the axial codes identified, "containment" (relying on model fidelity to reduce anxiety) and "inexperienced beliefs about change processes" (tendency to believe that changes in clients were a result of model adherence), were linked as both described "model-centred practice" used by inexperienced practitioners. "Model-centred practice" thus became a selective code.

Analysis was iterative and recursive. Memos were used to record thinking around emerging categories and the theoretical model (see appendix 7 for memos).

Quality assurance

Open coding was carried out independently by the researcher and a co-analyst and results were reviewed to ensure agreement. Coding, categorisation and theory were discussed with research supervisors. Additionally, three participants inspected coded transcripts to substantiate findings and provide respondent validity; no amendments were necessary. GT requires continuous cross-referencing of data, which reduced selective researcher bias.

Ethical considerations

Ethical approval was obtained from Canterbury Christ Church University's (Salomons) Ethics Panel (appendix 8) and a NHS trust's Research and Development department (appendix 4). It complied with all necessary code of ethics and conduct requirements (appendix 10).

Participants were not required to divulge personal or sensitive material, but clinicians potentially could have disclosed unethical practice. This was considered in the construction and delivery of questions. It was also discussed as part of participant consent protocol.

Results

Transcripts were analysed to consider what psychologists' language revealed about clinical practice. Categories formed in relation to when, why and how fidelity was used. Open coding produced subcategories that were broadly grouped into overarching categories, with all data eventually filtered into one encompassing category (see appendix 11 for coding table). Categories formed a GT of psychologists' evolving relationship with model fidelity (see figure.1 on page 77 for GT model). Key categories will be presented using a top-down approach (highest-order category described first, followed by intermediate categories and

their subcategories). Quotations from transcriptions are used to illustrate categorisation (see appendix 12 for example transcript).

Highest-order category: Internal drivers to meet needs

Woven within psychologists' discussions about practice/fidelity was a desire to meet needs: Their own needs as practitioners and most prominently, the needs of those they treated therapeutically. What was determined the best approach to achieve this altered with experience, but the decisions psychologists made, the way they responded to others and the way they practised (using model fidelity or otherwise) appeared to be governed by internal drivers to meet needs.

Intermediate category 1: Model-centred practice - generic understanding of needs

This intermediate category described a set of subcategories relating to model-centred therapeutic practice, described commonly in early clinical work. It was termed "generic understanding of needs" because participants typically referenced their means of conceptualising clients' needs as non-individualistic or formulaic. This stage was situated in opposition to descriptions of more personalised ways of conceptualising clients' needs, which evolved with experience. For instance, most participants retrospectively reflected upon times when model-centred practice drove or governed their clinical work and all differentiated between these and evolved approaches**.**

Subcategory1.1: Containment through model-centred practice

Having a protocol and model to adhere to made me feel less anxious when I started training. Strict model adherence can also be about managing the clinician's anxiety about getting it right, so I tended to want to adhere to manuals early-on. I think model

adherence can be useful early-on, because it can be containing for trainees to have some structure around what they're doing. (Coral)

For many at the start of their clinical careers, model fidelity provided a safety-net, a means of containing anxiety. Containment had practical implications; it helped trainees learn models and techniques in concrete, experiential manners. Fidelity also offered reassurance; using an evidenced model to treat clients was deemed "comforting" because it had been proven effective. Thus, fidelity's function was to reduce worry about therapists' (in)competency:

I always remember my supervisor instructing me to 'go back to the model' when I started training. There was something reassuring about having permission to only use one model. Something comforting about knowing there were hundreds of others out there I could ignore [...] in my head this made it OK for me not to know everything. (Julie)

There was also consideration that fidelity may have been safer for clients too:

When a person is new to practice, it's probably safer for the client if the therapist adheres to protocols because it protects the client and the therapist [...] It's an anxiety-provoking experience when you start out, and adhering to a model takes away some of the uncertainty. (Tammy)

At this stage, participants deemed model fidelity to meet their own needs as novice practitioners, but also to appropriately meet clients' needs because they had little experience to the contrary. High value was placed on efficacy research, which seemed to satisfy internal drivers to meet the needs of others.

Subcategory1.2: Model-centred beliefs about change

This subcategory was formed of participants' beliefs about change processes at the start of their clinical careers. Participants described faith in model fidelity for creating change. At this stage, locus of control for therapeutic effectiveness was situated within model compliance. Discussed retrospectively, these beliefs evolved with experience when more holistic beliefs about change processes were adopted:

> Looking back I have realised that when I started training I believed that if I followed models strictly I could fix the person. I blamed any failed intervention on my incompetency with the model or the client's disengagement with the model. I put all this power in the model like it was this mythical deity that could cure all ailments. (Melanie)

Some participants recollected upon their early conceptualisations of models as distinct from each other—beliefs that evolved:

> As a trainee, you are taught discreet models, so although there is also emphasis on reflection and integration, you do get a sense that each model is fundamentally different and that if you don't stick to one you are not working coherently. (Gillian)

Subcategory 1.3: Fitting people into models

Participants recollected upon processes of 'fitting people into models' during early clinical practice. Stephanie described her approach to therapy at this stage as "cookie-cutter", suggesting she made "the person 'fit' the model, rather than making the way I worked fit the person". Some participants recalled that their model-use was dependent on familiarity, not what was most appropriate for clients. As before, evolution followed with experience.

Participants recalled that the (then) unconscious act of fitting people into models was limiting, ineffective or inappropriate:

> I followed [...] models quite diligently when I started. I was using CBT initially and so I always seemed to focus on specific processes of change [...] But I'm not so sure how much this helped all of my clients [...] feels quite prescriptive to me, sort of like fitting people into nice neat little boxes and actually it's not always neat. Sometimes something else is needed. Now I am more confident picking and mixing [...] I think it is a sign of skill to be able to use mixed-methods that still should of course be based on a formulation. (Julie)

Subcategory 1.4: Learning and competency

> It's important to draw on theory and protocol if it fits and is useful, and to develop your competence in particular models so you know how to make the most of them [...] so the client experiences coherence in your work. (Gillian)

Fidelity as a means to aid learning and enhance clinical competency arose as a category. Psychologists referred to benefits of fidelity for breaking-down structure, principles, theory and techniques of models. It was generally deemed that working in a "pure" way early-on in clinical practice enhanced skill-acquisition and embedded knowledge. This was deemed to enhance competency in using models 'purely', which then enabled competent model integration. While model fidelity became less central to therapists' own practice as experience was gained, its value for managing, supervising or training novice clinicians was upheld.

> When I trained, particular placements involved working with one model over others and I think that's a helpful way of embedding learning, rather than trying to do lots of

things at the same time, to have a slightly purer experience of applying certain ways of thinking. [...] as I progressed through my career as a supervisor and manager, I had lots of conversations with people about times in therapy when you don't know what's the best approach: Stuckness. I try to encourage people to have a clear rationale, to think about models, and to be sure that they're formulating [...] so my experiences of model adherence as learning or teaching aids have been positive. (Veronica)

Intermediate category 2: Evolving practice – revaluating how to meet needs

The second intermediate category consisted of a number of subcategories describing evolutionary processes on therapists' practice. Participants described changes in the way they approached therapy as they gained experience and worked with a broader range of clients/models.

Subcategory 2.1: Encountering clinical complexity

The more I saw clients, the more I realised using one model for understanding human behaviour in complex cases just did not give sufficient understanding of their difficulties. I realised that cognitive-behavioural models don't explain the entirety of human behaviour. And anyway if the model explained all of the variance in therapeutic outcome, there would simply be no need for therapists and computerised therapies would be far more effective than they have proven to be. (Coral)

Participants referred to an evolving understanding of model fidelity's limitations following exposure to "clinical complexity". This altered practice with participants realising that "fitting people into therapeutic models" was not always possible and, for people with complex difficulties, doing so may not meet their needs:

I was obsessed with CBT when I began [but] after training it soon dawned on me that fidelity is really hard to do in the real world as models don't allow for the wide-scale differences seen in humans. My clients have complex problems that require a flexible and creative response and limiting myself to one paradigm takes away options. (Louise).

Subcategory 2.2: Discovering value in integration or eclectism

Some participants referred to evolving relationships with models stemming from multi-model practise, which lead to an increased awareness of the benefits of integration or eclectism:

Over time I began to see the benefits of different models. Things weren't so distinct for me. The more I've practiced and trained, the less I have adhered to specific models. I think every model makes a contribution [...] with complex cases, where there are longstanding relational problems, the therapeutic relationship is tested, the system is more stuck, you need as many lenses as possible to help you think and find ways of relating. I don't feel it's so helpful to feel like thinking needs to be informed by only one model. (Gillian).

Subcategory 2.3: confidence to experiment

Confidence was described by participants as impacting model fidelity. Psychologists referred to increased confidence in their practitioner abilities and courage to experiment with new practises.

I adhered much more to models during training, as a way of managing my anxiety. I feel a bit more able to be flexible in my approach since qualifying. If I'm doing CBT then I tend to adhere to a general CBT model, but often don't comply with the recommended timings for specific parts of intervention, adapting things to fit with the

person's pace and understanding. I will also draw on other models and techniques.

(Coral)

Graham referred to confidence in his ability to take risks when practising therapy:

I started to take risks in my practice when I started to question what I was really adhering to and the reasons why I was adhering. This curiosity stayed with me and it opens up possibilities for new ways of working because it makes me consider if it's always necessary to adhere. Confidence in my therapeutic skill has grown with experience and I might try different things with clients now [...] It challenges me to stay alert and mindful of what's happening in the room which I think I would be less skilled at if I constantly followed session-by-session protocols.

Subcategory 2.4: Developing intuition

Participants referred to a developing sense of clinical intuition that impacted upon practise:

I began to realise that it's not always quite as clear-cut as some of the more simplistic models advertise. It was something about working with depression. I learnt not to leap in and start recommending behavioural activation as directed. I guess it started to feel a bit superficial, when actually people have given me a quite complex story already. There's a lot more to it than just saying 'go out and do this and you might feel better'. Depression can be about so much more than low mood or inactivity, and it's my sense people often need more than a prescriptive type of therapy offers. That's not to say that behavioural activation is not of use [...] it's about knowing when the right time to introduce this is. You've got to read what's right for your clients [...] There's something else in between theory and practice [...] I believe it's something to do with what the therapist picks up about clients from one moment to the next. How they understand

things, covert and overt communications, motivations, feelings, relations. Manuals or

theory can't teach us that. (Sonia)

Intermediate category 3: Person-centred practice - individualistic understanding of needs

The third intermediate category consisted of a number of subcategories describing shifts to

more person-centred practice, with the individual client and idiosyncraticity driving therapy.

This signalled evolution from model-centred practice and a more critical, reflective and

holistic understanding of clients and the therapeutic process.

Subcategory 3.1: Adhering to the person

Dogmatic adherence to models, whilst useful in research, can stop clinicians' from

being responsive in the room [...] from working flexibly alongside their clients and

adapting their way of working to fit with the client. (Coral)

Participants discussed a tendency to move away from systematic model adherence or singular

theoretic paradigms towards adhering to the person being treated, which might merit model

adherence or not (a decision based on what is right for the individual). At this stage

guidelines informed decisions but did not dictate. Clinicians described looking past

diagnosis, using experience, creativity, skill and intuition to inform what works for whom,

under what circumstances.

For me therapy is all about person-centred principles [...] to tailor therapy to the

individual, so the kind of values I employ and how I relate to the person. I think I

genuinely try to adhere to person-centred values: empathy; unconditional positive

regard; genuineness. I think they're key [...] techniques or models (to me) aren't that

important. That's what I try to adhere to: the person. (Sonia)

Describing his approach to therapy, Drew said:

> As a psychologist, working with the way the person is in the room is more important to me than understanding whether they fit a particular model or diagnosis. I want to help ease people's distress and I am not too precious to avoid using certain approaches if they haven't been combined into a pre-existing treatment methodology. When choosing an approach I'd be thinking about suitability and what would work for that person. [...] I would not just offer a model because a guideline told me to. So having met with a person [...] I would consider which model or combination of models might be most advantageous for that person. I draw from experience and intuition, what may have worked for people in the past.

Gillian suggested theoretical adherence could be a barrier to person-centred practice:

> There is a constant internal dialogue to think of ways forward. That includes thinking of theory, questioning what you are attending to, why and how useful it is, and responding to feedback from the client. If you put treatment adherence first you can obfuscate all those other dialogues and ultimately theory might actually get in between you and your client. Having said that, I might still end up practising within a specific model, if that is what seems most appropriate.

Subcategory 3.2.: Multi-perspective understanding

Participants suggested that experience with different models granted multi-perspective understanding of people and their worlds. Participants described the practice of merging models or choosing techniques as necessary, regardless of paradigm. This was viewed as important for viewing clients holistically:

I was trained to formulate using multiple models [...] this helps me understand my clients and their needs in a holistic way. This also helps me develop idiosyncratic treatments dependent on the person and what they bring. And if that means borrowing from narrative approaches, using cognitive restructuring, or using attachment-based principles in the same intervention, and if that helps my client, then I will do that. (Tammy)

Describing model integration, Melanie said:

Sometimes you need to be flexible in your approach and adhering to a model when it clearly doesn't fit for an individual or is not working does not make any sense. When working with clients that face multi-faceted adversity it is often useful to have more than one way of understanding the difficulties [...] Often models are not explaining the same part of a problem [...] CBT models focus on symptoms and are diagnosis-led. This is often very useful for explaining certain aspects of the difficulties faced by clients but does not explain all aspects. [...] someone's attachment history may be very useful in helping the clinician understand how they engage in the therapeutic relationship and elicit help outside of the therapeutic arena. Systemic theory may help an individual take a broader view of their difficulties and help family members to change so that their view of the problem is not entirely located in the individual.

Subcategory 3.3.: Changing awareness of therapeutic processes

Participants described changing awareness of therapeutic processes that developed with experience. Commonly referenced were empathy, positive regard, containment, normalising, empowerment, collaboration and the importance of the therapeutic alliance. Generally, participants felt these processes were more important to adhere to than model protocols:

> Something I have learnt from experience is that adhering to protocols should never
> override other process factors as this can result in a rigid and sterile environment.
> Empathy, warmth, the ability to understand clients' thoughts, communications, hopes
> and goals are essential components of the therapeutic relationship and should never be
> overridden by model protocol. (Tammy)

In addition to relational processes between client and therapists, some psychologists referenced multi-faceted internal processes driving their work, combining science, practice and process:

> Mechanisms of change may not be as different or under our control as we think [...]
> What I try to adhere to is that constant internal dialogue [...] I try to stay curious, while
> still drawing on theory, evidence-base, and experience, I try to co-construct different
> hypotheses, to elicit different points of view that open up new ways of understanding,
> and new possibilities for relating to oneself and others. I adhere to a view that there is
> logic behind how one thinks and behaves, and that one's past, present and future
> context give you ways of understanding the logic and that frees you to make different
> choices. Equally, I think it's important to be future oriented, construct more hopeful
> stories, to draw on strengths and the fundamental belief that if you understand
> someone's context you can find the meaning of their behaviour. That helps me to
> remain compassionate and respectful. (Gillian)

Subcategory 3.4.: Identifying common factors in models

> In reality models are becoming more and more integrated. We are starting to
> understand the similarities between models and when and when not to use certain ideas,
> rather than think of models as completely separate and competing identities.
> Psychodynamic versus CBT; those arguments perhaps prevented us in thinking about

how things were similar and what was useful about both ways of working. That led

therapists into territorial arguments regarding their respective paradigms and that helps

no one [...] mentalisation is probably the most essential skill required of a therapist and

it transgresses all therapeutic modalities. (Tammy)

Participants alluded to developed understanding of similarities between models once deemed

distinct:

Over time you form certain beliefs about change in therapy, you see what different

models have to contribute to that, you realise the overlaps in the underlying theories of

change, and you think and practice more flexibly. I think the line between different

models is not always so clear cut. [...] If you explore someone's beliefs and

expectations about relationships, that conversation could be framed as CBT,

psychodynamic, or systemic [...] So even if I set out to use one of those models, how do

you know what the process of change is for the client really? [...] In different ways,

different models look to reframe the presenting problem; they give it a different context

and meaning. They invite the client to take a meta-position to the processes they get

caught up with, and so equip clients to make choices. They are not just intellectual

exercises-the ideas have to connect at an emotional level, whether that's through an

exposure exercise or through making powerful interpretations. Shifts in beliefs,

behaviour, emotion, and relationships will follow on from each other, but different

models target different parts of that process in different ways. (Gillian)

Intermediate category 4: Ambivalent relationship with fidelity

The final intermediate category encompassed themes relating to participants' ambivalence

towards model adherence, resulting from perceived organisational/political pressure, the

"medicalisation of psychology", discourses around mental health, guilt about non-adherence

and ambivalence towards the role of research in therapy. Overall it appeared that, although ambivalence was experienced, practice was generally unaffected; model adherence was employed if and when deemed appropriate.

Subcategory 4.1: Ambivalence towards model fidelity

> I question adherence to specific models [...] what are we constructing? What are we obfuscating? Why am I attending to certain things and not others? What discourses are informing what my client and I see as problems and solutions? How am I using my power and positioning myself as a therapist and what does this mean for the client's position? So it's not that I don't value adherence, it's that I worry that if taken to extremes, it comes at the expense of thoughtfulness, that it prioritises your agenda, and that it can get in between you and the client. (Gillian)

Participants revealed tendencies to view research more critically when reflecting on model fidelity in continuing practice. Whilst qualified psychologists felt model fidelity had utility in clinical psychology, most saw that being research-based or for treating focused problems.

> I think [model fidelity is] only useful if you have clients that can follow a model and understand it, and therefore they must not have very complex difficulties and they have to be receptive to listening [not] constantly needing to speak. So basically, they have to have one problem and be in the normal range and be quite intelligent, they have to be receptive to information, not just receptive to being listened to. That's an ideal. I think of myself as working broadly in the CBT model and I adhere as much as I can but unfortunately, models don't allow for much individual diversity, and if I was to adhere to the approaches the model dictated I would be doing my clients a disservice. (Sue)

Tammy suggested model fidelity was useful under certain circumstances, but questioned the applicability of theoretical fidelity:

> Some models are more easily manualised and lend themselves to easier evaluation. I can think of certain instances where being guided by protocol has been very helpful, as long as this does not lead to the therapist becoming rigid and inflexible in their approach and prevents them listening [...] Adhering to theoretical underpinnings of models and practices was perhaps more important when different modalities were developed under different paradigms, like positivist or social construction, but now so many therapies combine techniques from different modalities and I really don't see how it's possible to adhere to the original ethos that underpinned the theoretical frameworks.

Subcategory 4.2: Ambivalence towards research

> I think we have become too obsessed by the evidence-base, and I am slightly sceptical when it is for interventions about economic efficiency that often produce good-looking short-term results at the expense of making a long-term difference to people's lives. (Graham)

While most participants felt research had value, there was caution towards the "medicalisation" of psychology and the use of "eminence-based", "politicised", "non-reality based", "professionally divisive" RCTs to evidence intervention efficacy. It was generally agreed that what occurs in psychotherapy is difficult to define and better ways of measuring outcome and the therapeutic process should be found, rather than discounting research.

> I worry RCTs give an idea that therapy can be completely controlled, prescribed and will work the same for all people with a specific disorder, almost like a drug. It

sometimes seems like they are suggesting people are like machines that can be re-programmed to work better by inputting new CBT software [...] it gives the impression that a prescribed strictly adhered to model, if 'done' to a person, will cure them of the 'diagnosis', which is ridiculous. Whilst diagnostic criteria can at times be useful, a diagnosis actually suggests very little about why psychological interventions could be beneficial, it's simply a categorisation. I think clinical psychology accepts diagnostic criteria imposed by medically trained professionals too readily, adapts around it by devising specific models for these 'diagnoses' without questioning the possible self-serving/preserving nature of such diagnoses for medical colleagues. (Coral)

Subcategory 4.3: Expectation to adhere versus practice

I think fidelity is an ideal. It's something that I don't do and it makes me feel guilty, because it makes me feel that I'm not as good a psychologist as other people; however, then I talk to my colleagues and realise that they don't adhere to specific models either and that makes me feel better [...] we know what works and go with what works because that's best for our clients. [...] I value the idea of fidelity in terms of it might make me feel as though I'm a scientific practitioner, more like I deserve to get paid, but in terms of adhering to it religiously, I don't think it meets the needs of my clients. Of course there is the alternate view that not doing any model purely [...] means you lose some credibility [....] it doesn't feel good to dwell on that [...] if I just used Beckian CBT with my clients I'd be missing a trick and not paying full service to their situation so I use other approaches as well. I am possibly more scornful than is absolutely necessary about people who can be therapeutically pure and make it work [...] I doubt my ability to do this. (Sue)

Some participants referred to a sense of guilt for not practising fidelity to evidenced-based models due to self-imposed and (perceived) organisational expectation to adhere to certain models. However, this expectation was overridden by person-centred principles thus practice remained unaffected.

> I don't follow adherence protocols. The NICE guidelines are guidelines, and that's how I use them [...] Many services require that what is offered adheres to NICE guidelines and so it can feel that you are doing something 'naughty' if you are meant to be doing CBT and you bring 'other' ideas in to the room with the client. However, you have to use your clinical judgement and experience; otherwise you may as well be a robot who follows a manual with no capacity to think and apply your individual wisdom. When I started training I struggled to consider how different models could 'marry' within my practice; however, I feel that I have worked this out with time and experience [...] I would tend to keep my thoughts on this to myself though, as I am sure there are many purists or research-focused people who would judge negatively the kind of opinions that I hold about this. It can feel as though you are being bad for not being faithful to the model when you have been told that that is what you must do and it is where the evidence lies. (Gillian)

Summary

Results suggested psychologists' relationship with model fidelity was evolving and related to experience and expertise. Skills acquired included perceived ability to recognise processes of therapeutic change, to identify similarities between models, becoming more adept to working flexibly with complexity, and developing clinical intuition. These skills allowed psychologists to mediate between theory-driven models and human idiosyncracities in the

therapeutic space. Thus psychologists (subjectively) become better equipped to respond and adhere to clients' needs.

Data suggested model fidelity was more valued by psychologists during early clinical practice; it was deemed necessary to embed skills and provide containment, affording ability to integrate models or practise with fidelity as deemed necessary. Model fidelity became less important to psychologists' personal practice with greater experience, though it maintained importance as teaching/supervisory aids. Evolution from model-centric therapeutic approaches to more person-centric approaches was inferred. This evolutionary process appeared to elicit more critical and reflective stances towards model-use and ambivalence towards the role of research-based models in clinical practice.

Figure 1: Model of psychologists' evolving relationship with model fidelity

Motivation to meet the needs

of self and others drives/encompasses

each stage

Stage 1: Model-centred practice - generic understanding of needs

Belief that models are distinct

Models are containing – safer for clinician, safer for client, evidence-based.

Model-centred beliefs about processes of change –

Adherence is the best way to help. Value in simplifying for learning

Fitting people into models

Stage 3: Person-centred practice - individualistic understanding of needs

Adhering to the person, making therapy fit the person

Using what works - multi-perspective understanding

Changing awareness of therapeutic processes

Identifying common factors in models

Stage 2: Factors leading to evolved practice:

Confidence using models and in one's own competencies

Treating complexity – some people don't fit into models

Discovering value in integration or eclectism

Developing clinical intuition – what works for whom.

Stage 4: Ambivalent relationship with fidelity

Ambivalence towards role of research

Expectation versus practice

Guilt for non-adherence

Discussion

Model-centred practitioner evolving towards integration

Yalom (1989) once suggested psychotherapy theories developed to reduce therapists' anxieties about therapeutic complexities/uncertainties; thus inexperienced practitioners would arguably value model fidelity more because propensity for trainees to be anxious is greater (Hayes & Gelso, 1991). This study corroborated this. Practitioners reflected that model fidelity was a means to contain anxiety when training began, deeming it safer for them and their clients.

The GT suggested experience was linked to psychologists' perception of model fidelity's utility. Generally, psychologists believed model fidelity was advantageous as a learning aid when training. Links between experience and practice have been found in prior research. Several studies (Addis & Krasnow, 2001; Aarons, 2004; Aarons & Palinkas, 2007; Berke et al., 2011) found relationships between clinical (in)experience, adherence to EBTs and attitudes towards EBTs: The greater experienced the clinician, the less adherent and more negative their attitudes towards EBTs.

The GT added to current literature, offering insight into why novice psychologists practice as they do. Findings suggested that, when psychologists began training, they were oriented to model-centric practice because of drivers to meet the needs of 'others' (model-centred approaches were deemed most affective to alleviate clients' distress), drivers to meet their own needs (model-centred approaches were containing and aided learning), because of non-experientially-based belief systems about research, therapy and change processes, or due to influence by models during training. Evolution of clinical practice occurred due to experientially-based factors (e.g. exposure to clinical complexity; familiarity with multiple models). Assimilative model/skill integration occurred in tandem with confidence and

clinical-intuition, all perceptively enriching therapists' propensity to understand their clients. This process could be seen to corroborate Werner's (1948) organismic-developmental-theory as it supports the presence of experientially-based evolutionary processes, leading to skill-differentiation and the ability to integrate skill components (i.e. models) once perceptively separate. Psychologists referenced to discovering a value in integration or eclectism and being able to tailor treatment idiosyncratically. This corroborates prior research suggesting self-identified eclectics/integrationists switched from singular-model practice upon discovering no singular theory/model explained human variance (Norcross et al. 2005).

Person centred practitioner: Critical, reflective, integrative, holistic

Discussing psychotherapy integration, Jones-Smith (2011) suggested integration enhances therapists' ability to choose the most appropriate treatment for clients, without the hindrance of theoretic division. Psychologists in this research shared this belief; they described evolution towards an advanced understanding of what, why, and when to use therapeutic approaches. Psychologists evolved to intuitively tailor therapy to each person's needs, integrating theory/models and evaluating/using evidence as necessary. More critical, reflective and holistic ways of working underscored this stage. Models were no longer perceptively distinct; common processes became identifiable and views that therapeutic practices had evolved into personal styles were adopted. This could be seen to corroborate Schon's (1987) espoused theory, which suggests experience and reflexive activity cause integration of prior knowledge to create something 'new', suggesting practitioners evolve their own personalised way of working.

Norcross (2005) pointed out that practising integrationists make use of multiple change processes via theoretical integration, common-factors approaches, assimilative integration and technical eclectism; the present study suggested these practices are

experientially/expertise-based and the ability to identify common-factors and therapeutic processes were distinctly acknowledged within this research. Norcross (2005) has described "common-factors" as the process of identifying core/common ingredients of therapies to create more "parsimonious and efficacious treatments based on their commonalities". The common-factors approach to integration was influenced by Rogers (1957), a pioneer of person-centered therapy. Research has shown the therapeutic alliance (a person-centred variable) is vitally important to treatment outcome (Hubble, Duncan, & Miller, 1999). Rogers proposed therapists create core relational conditions such as respect, empathy and genuineness and that these variables, deemed common to each therapy, create therapeutic change. Meta-analyses (e.g. Elliott, Greenberg & Lietaer, 2004; Elliott & Freire, 2009) of person-centred approaches have shown high degrees of pre-post changes with long-term gains at follow-up. They have also been shown to be as statistically and clinically effective as other therapies (CBT and psychodynamic psychotherapy; Miller & Duncan, 2000; Stiles, Barkham, Twigg, Mellor-Clark, 2006). In the present study, Rogerian person-centred variables were deemed of importance to psychologists, but these were not the only ingredients deemed important for change. Person-centred practice in this study included individualised care and use of therapeutic techniques afforded by experience—drawing upon multiple theories/models to enhance person-centred understanding.

Ambivalent relationship with fidelity

The GT suggested that, upon evolving to person-centred practice, an ambivalent relationship with model-based fidelity occurred, impacted by perceived pressure to practise using EBTs, guilt about non-adherence, and ambivalence towards the role of research in therapy. These findings corroborate research by Altman (2001), who found practitioners deemed findings from research to be ungeneralisible to practice. In the present study, ambivalence seemed to

result from psychologists' awareness of the importance of research in clinical work and uncertainty about incorporating these findings into practice. Generally, participants agreed that research-based models may address some of their clients' needs some of the time. Brems, Johnson and Gallucci (1996) found similar ambivalence regarding the adoption of research-based practice in psychologists. Taken together, these results might infer that efficacy research may not be adequately resonating with practising psychologists.

The Department of Health (2001) suggests EBTs should be primary treatments. However, as Spinelli (2001) suggested, the term "evidence" offers connotations of certainty, and most therapists learn that certainty is not conducive within the fluid, ever-changing therapeutic space; hence the "research to practice gap", a mismatch between the uncertainty of humans and the certainty of research. It seemed for experienced psychologists in this study, deciding to practise (or not) with fidelity to EBTs might foster anxiety, guilt, confusion and ambivalence, possibly because EBTs have links to professional accountability and the scientist-practitioner model to which psychologists' are taught to aspire. Nonetheless, participants' practice remained person-centred not model-centred, despite the ambivalence. Participants' concern was less about empirical evidence from a population perspective and more about how research might be applicable to the individual; this might mean practising with fidelity to evidenced-based models, or not. Thus, practice seemed consolidated at this stage. This phenomenon was similarly noted by Jones-Smith's (2011) in her model of professional development. Jones-Smith suggested that therapists' practice consolidates once they accept their therapeutic approaches have evolved into personal styles, based on what works.

Implications

Clinical implications

This research suggested that although model fidelity was valued for training and skill-acquisition, clinical practice evolved with experience. This resulted in person-centered adherence that potentially included model integration or model fidelity, and was generally individualistic to each client-therapist dyad. Participants suggested strict fidelity may not appropriately service the needs of complex clients, precludes change processes that multi-model practice offers, and that research-based models insufficiently consider covert therapeutic processes/skills (clinical intuition, person-centered variables, alliance), or the individualistic therapeutic journeys clients and therapists undertake. Fidelity was at times deemed undesirable/unfeasible, depending on the client and their problem(s).

Individualistic, integrative approaches might arguably be incongruent with standardised EBTs. In 2001, the UK's Department of Health documented a therapy hierarchy based on efficacy research gleaned from RCTs. While usefulness of RCTs was undisputed by participants in this study, there were suggestions that such research methods insufficiently assessed the individualized, person-centric, co-constructed understanding between therapist and client. Health services might therefore benefit from being more inclusive in research methodologies they accept as evidence. RCTs glean valuable information about therapeutic models from a population stance, but there may be equal value in using other forms of research to investigate therapeutic processes, results of which could have implications on what is deemed efficacious and would enable a developing understanding of person-centric, individualized practice. Clinical psychologists, whose training involves research components, are positioned to use their skills to accrue evidence gleaned from practice-wisdom and

explore relationships between practice, theory, models and EBTs. This could enrich

therapeutic practice for clinicians, offer a means to validate and show benefits

(therapeutically and economically) of hard to standardize therapies, and confirm to service

commissioners and clients alike that certain therapies are ethical.

Research implications

Marrying research and human science is a well-documented conundrum (Spinelli, 2001).

Different therapeutic models have differing assumptions, change processes, and techniques. It

therefore seems plausible that differing approaches to efficacy might be warranted for such a

range. Interpretative, alliance-based, idiosyncratic, integrative and eclectic forms of therapy

are by nature difficult to research and impossible to standardise as each process differs from

client to client. In the current socio-economical climate, there is focus on efficient results in

mental health services, and perhaps as a consequence, difficult to evidence therapies have

been overlooked; yet such therapies have not proven ineffective either and the UK's

Department of Health (2001) acknowledges that there may be benefits in (as yet)

unevidenced therapies.

More holistic understandings of models based on practice wisdom might help to bridge the

gap between research and practice. In addition to RCTs, case studies and qualitative forms of

analysis to explore uniqueness of personalised approaches might merit consideration in

efficacy research. Acknowledging a tendency towards patient-centred care would mean that

clinical procedures need exploring wherever possible (Williams & Grant, 1998).

Clinical training implications

Findings from this study could also have implications for clinical psychology training. There

may be differences on clinical psychology training courses in regard to focus on therapeutic

models, with those prioritising the scientist-practitioner model emphasising models that have scientific/research/evidence backing (Kennedy & Llewelyn, 2001). There may also be more focus on teaching quantitative methods of psychometric assessment over qualitative, experientially-based forms of data collection. However, the present study suggested that experienced practitioners prioritize person-centered approaches over evidence-based ones, and their therapeutic approaches might include the integration of different models if deemed appropriate. Furthermore, participants inferred that fidelity to evidence-based models may (at times) be inappropriate when working with clients with complex needs. An argument could thus be made for more universality on clinical psychology training courses to ensure equal emphasis is given to training skills such as model integration and qualitative research methodologies, in addition to evidence-based practices.

Limitations

Although adequate data saturation perceptively occurred, Strauss and Corbin (1998) suggest this accomplishment is hard to assess objectively. This, as well as the small, self-selected, trust-specific sample merits consideration when interpreting results. Furthermore, owing to time/resource restrictions, recruitment was restricted to clinical psychologists, limiting applicability to other therapeutic disciplines.

Demand characteristics may have impacted results. Mental-health services are increasingly endorsing fidelity to EBTs, so practitioners may have underreported opinions on certain models. By design, the researcher influenced all aspects of the study and it was not possible to conduct research without prior knowledge of this subject matter. Charmaz (2006) would therefore suggest that GT models may be better understood as socially constructed between researcher and participants.

Future research

Further, larger-scale research would be warranted to substantiate this GT's findings. Taking this research forward might include comparatives between self-identified purists and multi-model practitioners. Strategically sampling for differences in clinical-experience would allow for broader comparisons and richer understanding of the relationship between experience and model fidelity, and between ambivalence towards model fidelity (i.e. if guilt/ambivalence reduces with more experience). Longitudinal work may be beneficial to accurately monitor changes over time. Using case-studies, observations, process notes, clinician diaries, or client feedback might further enrich understanding of model-use.

Conclusions

The GT suggested clinical psychologists' relationship with model-fidelity evolved with experience. Experienced psychologists do not practice linearly; many variables contributed to therapeutic processes. Model fidelity, despite being deemed important for research and skill-acquisition, was not the main impetus driving experienced psychologists' practice. Instead, person-centered approaches to practice evolved, with psychologists using empirical evidence to inform but not dictate model use. Psychologists evolved perceived skills in clinical-intuition, an ability to recognise processes of therapeutic change, to identify similarities between models and to integrate or practice eclectically. This evolution seemingly elicited a more critical and reflective stance towards model use and ambivalence towards the role of research-based models in clinical practice, corroborating the well-documented chasm between research and practice. To lessen this gap, resources could be invested into researching practice wisdom to aid experiential understandings of therapeutic processes and to challenge the rhetoric that only RCTs offer 'evidence'.

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Section C

Critical Appraisal

Stefan Peart

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A thesis submitted in partial fulfilment of the requirements of

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Doctor of Clinical Psychology

1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

My research experience prior to beginning this doctorate was largely quantitative. There was little focus on qualitative methodologies during both my undergraduate and graduate degrees and although I had performed a service evaluation during training using content analysis, this was a small and focused piece of work; not in the same league as a Major Research Project (MRP). The greatest challenge for me, therefore, was seeing past the discourses that had been constructed in my mind about what was deemed valuable research and what was not. Firstly, I was more comfortable using self-report measures and statistics to test for clinical significance, as this is what I had used primarily in my other degrees. Secondly, I realised that a large part of me felt statistical methods to be more scientifically valid than qualitative methodologies. I had a bias against qualitative methodologies, believing them to be mostly subjective accounts from researchers and only viewed them as valuable in a complementary manner to quantitative approaches. Being aware of my biases and knowing that Salomons is inclusive in their stance on qualitative research, I felt that it was all the more important for me to challenge these biases. I did this by undertaking a qualitative MRP.

Beginning somewhat from the position of novice, almost all aspects of qualitative methods were new to me; as such, I gained a wide range of skills. Constructing and conducting semi-structured interviews were key skills learnt. It was important for me to devise logical and clear questions that answered my research's topic. It was also important that I constructed the interviews in a manner enabling me to manoeuvre back-and-forth between questions and topics if necessary. The conversational process of semi-structured interviewing meant that interviewees might naturally deviate onto other subjects, and I needed to be prepared to guide

the interview back into the realms of the research's focus. A qualitative interviewer has to be skilled in "holding the frame" of the subject matter during the interview, but also in allowing the conversation to be free-flowing to generate rich data for deeper analysis. This took practice. My initial interviews were quite stilted and systematic; data was much less fertile as a result. This altered with practice and I became more comfortable with the format and more familiar with the subject matter. I broadly kept in mind and used methods of interviewing as outlined by Kvale (1996): Introducing questions, follow-up questions, probing questions, specifying questions, direct or indirect questions, structuring questions, interpreting questions and silence.

Identifying the 'population validity' necessary for qualitative methods was another skill that developed. Using quantitative methods and random sampling based on power calculations had been the norm for me up until then, but this piece of qualitative research would be focusing on opinions and experiences of professionals with direct experience. Choosing the most appropriate participants was important, so purposive sampling was required. Other skills to do with the interview process were experiential, learnt largely through trial and error, such as technicalities (dos and don'ts) of digital recording and interview transcription. I learnt early on that the transcription process enabled evolution in my interviewing skills, because after doing an interview and transcribing the data, I was able to reflect on how it had gone, and what I could do differently in subsequent interviews. This was a valuable part of my learning curve in becoming adept at semi-structured interviewing.

My research skills developed during the analysis process. I studied varying methodologies before settling upon grounded theory, which was deemed most appropriate as I was exploring practice wisdom directly from participants' experience and it also enabled me to produce a theory (Bryant & Charmaz, 2007). The process of choosing the best approach to grounded

theory was informative and catapulted me into a critical style of thinking as I weighed up the pros and cons of each grounded theory methodology and decided which suited me and my project. Strauss and Corbin's (1998) approach was chosen as it afforded structure which was beneficial for me as a novice grounded theorist. It also enabled the use of validation criteria. Analysis was a long process. It was daunting initially and hard to entertain the possibility that, from this data, I needed to establish a coherent grounded theory and model. I went through periods of feeling hopeless and intimidated by grounded theory, born from inexperience and self-doubt. There were long periods of procrastination involved during the early stages of analysis; this only made the task feel more daunting. However as Charmaz (2006) has suggested, despair is part of the process of grounded theory analysis. I felt validated in this, having spoken to colleagues who experienced similar feelings of despair. Ultimately, I was able to push past the despondence and began to relax with the data and immerse myself with it during coding, the initial stage of comparative analysis (Glaser, 1978; Strauss & Corbin, 1990). Instead of desperately trying to generate theory from scratch, I stopped trying to force the process, but kept a clear but curious stance, trying not to let what I had learnt or read beforehand influence what the data was telling me. During data immersion, I became more relaxed with the process; the sense of initial urgency was lost as a theory generated naturally from the data. Knowing the ups and downs of this process will serve me in the future, should I perform more research using grounded theory. I will hopefully be more adept at familiarizing myself with the data and not trying to force the process of theoretical generation from the outset.

Overall, the process drastically altered my stance on qualitative research methods: The skills that are needed, its legitimacy, and its contribution to human sciences. While I learnt much, there is much yet to learn about grounded theory; while some of this can be done through

study of epistemologies, I believe learning will mostly be achieved experientially. Furthermore, there are many other qualitative approaches to try and master and I am hopeful I will gain experience using a wider range of methodologies in the future.

2. **If you were able to do this project again, what would you do differently and why?**

My project was based on practice wisdom of clinical psychologists. If I were able to perform a larger scale piece of research, I would have included interviews with service users. By training, psychologists possess skills and knowledge about human behaviour and relationships that non-clinicians do not have. Thus, the way psychologists construct the therapeutic process may differ greatly from non-professionals. It would have been of great interest to me and (of use to clinical psychology in general) to assess whether service users experienced the therapeutic process in the same way as the psychologists. Psychologists felt their practice became more person-centred with experience, and that this positively impacted upon clients and the therapeutic relationship. However, unless corroborated with service user experiences, findings remain biased/one-sided.

I would have liked to broaden the scope of the research by sampling professionals from other disciplines in addition to psychology. I am aware that, in addition to clinical psychologists, counsellors, psychiatrists, counselling psychologists, nurse practitioners, psychotherapists, IAPT workers, family therapists, occupational therapists and social workers have been trained to use therapies. In hindsight, I would have sought interviews from a more diverse range of clinicians so results could be applied more widely among the therapeutic community.

From a procedural stance, I think that there would be fewer propensities for bias in qualitative research if the researcher is able to minimise exposure to literary debate on the research topic as much as possible. The nature of composing a study means that complete avoidance is impossible, but if I had my time again, I might, for instance, limit my review of related literature before analysis, as I cannot truly know how much I was influenced by ideas of others in my theory generation.

3. **Clinically**, **as a consequence of doing this study, would you do anything differently and why?**

For me, the implications gleaned from this study spoke to me as a future clinical psychologist. They highlighted the importance of defining person-centred, idiosyncratic approaches as practised by clinical psychologists, and of conducting and generating evidence from practice wisdom. This research highlighted to me that RCTs cannot inform about every process of therapeutic practice; in addition to RCTs, other research methods are needed to better understand these. Due to research training, clinical psychologists are in a position to contribute to a more eclectic understanding of what is deemed 'evidence'. As a result, I might, for instance, be more inclined to consider using case studies as a mainstay of my work, or be more inclined to integrate qualitative and quantitative research methodologies as part of my clinical role and audit. It has been shown that after qualifying many clinical psychologists do not go on to publish further research (Holtum & Goble, 2006). My MRP has highlighted that continued research after qualifying would be a potential means to challenge current discourses around what is deemed acceptable as evidence. By incorporating research and data gathering as a key part of clinical routine, using varying research methods, I believe clinical psychologists could advance broader understanding of therapeutic processes. This could have positive consequences for both mental health professionals and their clients, who

might benefit from being offered potentially efficacious treatments that have yet to be evidenced by RCTs. This research has highlighted to me the importance of documenting clinical practice and process during one's career.

4. **If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?**

To take this research further, I would like to recruit and interview a broader range of therapists to see whether findings seen within this research are corroborated. I would also like to compare therapeutic disciplines as this research only sampled clinical psychologists. It could be hypothesised, for instance, that practitioners trained in only one model (such as IAPT therapists) might be more inclined to practice with fidelity than clinical psychologists, who are multi-model trained. However, the present research indicated that integrating theory and models is not the only process that impacts clinical psychologists' practice and it would be useful to explore whether the reported evolution from model-centred to person-centred practice is present in other disciplines. Further research to corroborate, compare and contrast would be beneficial to the therapeutic profession, not just clinical psychologists. Developing the understanding of therapists' relationship with model-use could involve other methods for analysis: Quantitative methods, longitudinal research using follow-up interviews, practitioner case-studies, observations, process notes, clinician diaries, or service user feedback might enrich understanding of model-use further.

The ambivalence and guilt factors associated with psychologists not practising with fidelity to EBTs was an interesting result of this study that would merit more focused research via interviewing. For this sample, practice was not altered despite some psychologists feeling guilty for non-adherence. Some suggested that they would not broadcast non-adherence, fearing this would be viewed critically by colleagues or frowned upon at an organisational

level. This posed interesting questions about the perceived pressure psychologists might feel to adhere to certain models, particularly given that it would seem clinical practice is about more than dogmatic model fidelity. Furthermore, I am interested in the way that covert therapeutic practice might actually serve to collude with the discourses that surround fidelity to EBTs in clinical practice.

Psychologists in my research tended to become more critical of research-based models with experience, largely because they were deemed not to capture the complexities of the therapeutic process fully. I would therefore be interested to explore in what way psychologists would seek to evidence the therapeutic process instead and how to implement such strategies from an experiential view-point.

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Section D: Appendices of supporting material

Stefan Peart

Appendix 1: Literature search strategies

Databases were searched from inception through to February 2013 with no limitation on dates. The following databases were used: Cochrane Database of Systematic Reviews; Ovid Medline; PsycINFO; Google Scholar; Pubmed; Assia; Web of Science. All databases were searched using a combination of the following search terms, their synonyms and derivatives, in title, abstract, key words or key concepts using Boolean operators to identify relevant papers. No limitations on publication dates were implemented. Screening of relevant articles' references was carried out to identify other potential articles. Electronic and manual cross-checking as well as author searches were performed, ensuring all relevant articles had been identified. Governmental, NHS, the Department of Health, BPS, NICE, BACP, BABCP, BPC, HCPC, NCS, Society of Clinical Psychology, APA, RCP, IAPT, UKAHPP and service websites were searched for policy documents or relevant material pertaining to model fidelity, EBTs and therapeutic practice

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Search criteria

1) Search terms for practice of fidelity: Fidelity; Adherence; Integrity; Implementation; Competence; Faithful implementation; Conformity.

2) Search terms relating to treatment models and practice: Model; Therapy; Treatment; Therapeutic intervention; Evidence-based (treatment, therapies; practice); Manualised-based therapy; Treatment manuals; Protocol; Clinical practice.

3) Search terms relating to clinicians: Clinicians; Therapists; Practitioners; Mental Health workers; Psychologists; Clinical Psychologists; Psychotherapist; family therapist; Employees; social workers; nurse (practitioner); IAPT; Graduate mental health worker; facilitators; supervisors.

4) Search terms attitudes: Attitudes; Opinion; Experience; Preference; Belief; Values; Judgement; Bias; Relationship.

Inclusion/exclusion criteria

Studies were considered for review if search items from criteria 1, 2, 3 and 4 were combined in the article's title, keywords, text, or abstract. Quantitative studies were selected for inclusion if a measurement of clinicians' attitudes/opinions about model usage was included in the study. Non peer reviewed articles, foreign-language articles, dissertations, secondary-sources, and book reviews were excluded. As this study reviewed clinicians' attitudes towards model fidelity, studies that solely measured model fidelity from an efficacy perspective were excluded as this study hoped to review literature on practice wisdom from practitioners.

Appendix 2: Summary table of reviewed studies

Authors and Method	Aims	Sample	Findings	Critique
Addis and Krasnow (2000) **Qunatitative:** *Survey of attitudes (52-item self-report)	*To perform a national survey of practitioners' attitudes towards manualised EBTs. *Identify a range of positive and negative attitudes towards the role of manulised EBTs in practice	*891 licensed psychologists from US randomly selected from APA database. *Two most common self-described theoretical orientations were cognitivebehavioral (43%) and psychodynamic/analytic (24%).	*Psychologists held widely differing attitudes: positive (34%), negative (21%), neutral (45%). * Practitioners reported range of experience with Manualised EBTs. *Therapists holding negative attitudes towards Manulised EBTs valued clinical flexibility, autonomy, therapeutic alliance, individualised case formulation. * Less experienced psychologists were more favourable. * Psychodynamic/analytic-oriented clinicians showed significantly higher negativ attitudes than cognitive-behaviorally oriented clinicians. *Complex disorders like PD were deemed less suitable for manualised EBTs.	*Large widespread sample but low response rate of 30% *Randomly selected sample * Range and percentages of theoretical orientations were consistent with a survey of APA Division 12 circa 2000; supports generalizability to US at that time. *Non-UK generalisable *Prone to self-report bias. *Possible response bias *Method did not permit follow-up/clarification of attitudes.
Gaudiano, Brown and Miller (2011). **Quantitative:** *Internet-based surveys: * Evidence-Based Practice Attitude Scale: attitudes towards EBTs. *Rational-Experiential Inventory (REI): rational and experiential/intuitive thinking *Complementary and Alternative Medicine Health Belief Questionnaire (CHBQ): beliefs about complementary and alternative medicine. *Magical Beliefs about Food and Health Scale (MFH):magical beliefs about food and health-related issues.	*To examine the relationship between intuition and therapists' attitudes towards EBTs.	*288 US-licensed therapists.	*Intuitive thinking associated with more negative attitudes towards research, less openness to research-based treatments, and less willingness to use EBTs if required, even after controlling for confounding factors. *Supports preference for clinical flexibility as opposed to strict adherence. *Tendency to rely on intuition associated with more positive attitudes towards alternative therapies and the endorsement of erroneous health beliefs.	*Modest sample *Regression analyses controlled for many confounding variables *US-based, non UK generalisable *Self-report bias *Response bias *Recruitment bias *Use of standardised measures *Cross-sectional data limits cause affect *Only attitudes measured to EBTs. EBT practice not measured.

Aarons (2004) **Quantitative** *Evidence-Based Practice Attitude Scale (EBPAS)	*To develop a measure of mental health provider attitudes toward adoption of EBTs *Attitudes examined in relation to individual differences and organizational characteristics	*322 public sector clinical service workers from 51 programs providing mental health services to children and adolescents and their families.	*Four dimensions of attitudes toward adoption of EBPs: intuitive Appeal; Requirements to adopt; Openness; Divergence of usual practice with research-based interventions. *Supports theories on diffusion of innovation *Attitudes varied by education level, level of experience, and organizational context. *Less experienced practitioners valued EBTs more.	*US-based *Non-generalisable to UK *Study lacked any critique of its methodology *Development of scale: the author appears to have not considered client complexity, idiosyncratic formulation, or therapeutic process variables in detail.
Aarons and Palinkas (2007) **Qualitative:** *Semi structured interviews *Grounded theory	* To better understand the implementation process of EBTs in a children's service	*17 therapists *Maximum variation sampling	*Six primary factors were identified as determinants of EBT-use : (1) Acceptability of the EBP to the caseworker and to the family, (2) Suitability of the EBP to the needs of the family, (3) Caseworker motivations for using the EBP, (4) Experiences with being trained in the EBP, (5) Extent of organizational support for EBP implementation, and (6) Impact of EBP on process and outcome of services. *Factors found to reflect two broader themes of attitudes toward or assessments of the EBP itself and experiences with learning and delivering the EBP. *Implementation seen as a consequence of perseverance, experience,and flexibility, complexity, therapeutic relationship *Theory links to Rogers' diffusion of innovative practice	*In-depth description of analysis process *Inter-rater reliability performed *US-based Non-UK applicable *Service specific. *Participant demographics (orientation, age) not included restricting comparisons. *Small sample *Maximum variation sampling allowed for greatest variation in opinion represented in the study but sampling method could indicate recruitment bias. *Presence of demand characteristics
Godley, White, Diamond, Passetti and Titus (2001) **Qualitative**: *Thematic analysis *Multisite, randomized field experiment	*Describe therapist reactions to the use of manualised EBTs	*16 therapists and 3 case managers who provided the treatments.	*Perceived clinical 'complexity' and cormorbidity influenced psychologists' endorsement of manualised EBTs. *Therapists endorsed or opposed models based on perceived allowances for individual case conceptualisation *Manualised EBTs felt did not allow therapists to address individual needs. *Flexibility a theme: The more structured the EBT, the less liked it was by therapists	*US-based *Non-UK applicable *Strong theme identification *No consideration of reflexivity *No contribution to theory * Inter-rater reliability

Nelson, Steele and Mize (2006) **Qualitative**: *Thematic analysis *Focus groups	*To investigate practitioner attitudes towards EBTs in community teams.	*19 therapists from 2 community teams	*Practitioner concerns regarding applicability of research supporting EBTs *Practitioners that valued flexibility and the therapeutic alliance were less likely to endorse EBTs. *Practitioners more likely to deviate when presented with clinical complexity *Found that research generally does not impact upon treatment selection. * clinical creativity when using EBTs was related to positive attitudes towards the model	*US-based *Non-UK applicable *Presence of demand characteristics (researcher and other Pp in focus group).
Freiheit, Vye, Swan, and Cady (2004) **Quantitative**: *14-item survey, "Treatment of Anxiety Disorders." *Questionnaire of therapeutic techniques checklist.	*To assess EBT usage for anxiety disorders	*189 CBT-Oriented psychologists randomly selected from Minnesota board of psychology listing.	*Therapists endorsed EBTs because of research backing *Approaches often did not conform to empirically-supported CBT protocols *Disorder specific techniques affiliated to other models were used across CBT approaches for anxiety disorders, and that prescribed exposure-based interventions were rarely used despite strong empirical support.	*US-based from one state; Non-UK generalisable *Non-standardised measure *Self-report/response bias *Presence of demand characteristics *Homogenous sample limits generalisiblilty to other models.
Mullen and Bacon (2006) **Mixed method:** *Quantitative: Survey assessing EBT usage and demographics *Qualitative: Content analysis on descriptive data from survey.	*Assesses attitudes towards the use of EBTs	*81 Social workers 16 Psychologists Psychiatrists 10 Other mental health worker *(Only data from psychologists considered in this review as they practiced therapy).	* Psychologists who felt clients had complex needs were unlikely to practice with fidelity to EBTs. *Manualised EBTs constrained clinical judgement, professional autonomy and the therapeutic process *EBTs accused of being limiting.	*US-based; Non-UK applicable *Mostly presented as descriptive data *No description of process of thematic analysis on content. *No links with theory *Small sample of therapists *Data saturation seemed unlikely as interviews were not performed for qualitative data. *Limitations not considered in detail, although the authors do acknowledge that the sample of psychologists is too small to be representative.

Norcross, Karpiak, and Lister (2005) **Quantitative** *Questionnaire:5-point, Likert-type scale *Replication and extensions of Garfield and Kurtz's (1977) and Norcross and Poskanka (1988) studies.	*Investigate views and practices of self-identified eclectic and integrative psychologists in the United States.	*187 eclectic clinical psychologists *Randomly selected members of Division 12 (Clinical Psychology) of the American Psychological Association (APA).	*50% psychologists previously adhered to another theoretical orientation *85% defined eclecticism/integration as endorsement of a broader theoretic orientation. *Most common integration style practised were theoretical integration, common factors, and assimilative integration, as opposed to technical eclecticism. *Most frequent theoretical contributor to integration was cognitive therapy.	*US-based; Non-UK generalisable *Only used Division 12 psychologists *Supports theories on differing forms of integration *Non-standardised measures *No objective measure of practice, only self-report.
Najavits, Weiss, Shaw and Dierberger (2000) **Quantitative**: *Survey *56-item survey was developed specifically for this study on the basis of a literature review designed to identify key issues in use of manualised EBT	*To explore how useful therapists find manualised EBTs.	*47 primarily CBT-oriented psychotherapists *Therapists were recruited by word-of-mouth and at a national CB conference.	*therapists generally positive towards fidelity to manualised EBTs *reasons for use of EBTs largely intrinsic--a quest to improve skills and intellectual curiosity- *Therapists appeared to value manuals most for their clinical Contribution and contribution to research. *Therapists look to manuals as a problem-solving resource.	*US-based; Non-UK generalisable *Incentive offered to subjects and word of mouth sampling compromises internal validity – selection bias *Therapists of other theoretical orientations might express more negative opinions. *Unvalidated measure *Relatively small sample size *No evaluation of the relationship between therapists' attitudes and their actual performance
Norcross and Prochaska (1988) **Quantitative** *Replicated and extended Garfield and Kurtz's survey (1977).	*Investigate views and practices of eclectics	*113 self-designated eclectic clinicians	*58% psychologists previously adhered to one theoretical orientation, typically psychodynamic (44%) or behavioral (27%). *Most frequent theoretical combinations were cognitive-behavioral, humanistic-cognitive, and psychoanalytic-cognitive. *Three methods of eclecticism were pragmatically selecting whichever best fit; combining theories; integrating a number of therapies.	*US-based; Non-UK generalisable *Supports theories on differing forms of integration *Only used Division 12 psychologists *Non-stadardised measures *No objective measure of practice, only self-report.

Garfield and Krutz (1977) **Quantitative** *Survey assessing practice of eclectic psychologists	*To study the views/attitudes of eclectic psychologists	*154 clinical psychologists who had designated themselves as eclectics	*Commonalities and differences were found in characterization of theoretical views. *Great diversity of combinations of theoretical views and therapeutic techniques. * A common theme among eclectics was that no one theory was adequate for treating diversity of clients seen in practice *clinicians selected approach that best fits a given client.	*US-based; Non-UK generalisable *Supports differing forms of integration in therapist practice. *Only sampled Division 12 psychologists – limits generalisability. *Non-standardised questionnaires used; descriptive nature is a limitation. *Study old and dated, practice changed particularly in respect to EBT movement. * No objective measure of practice, only self-report.
Thoma and Cecero (2009) **Quantitative**: *Commercial online survey *Therapist Techniques Survey Questionnaire (TTSQ) *127 specific techniques on a 5-point Likert scale	*Explore if therapists of a given orientation endorsed techniques from that orientation more than therapists of other orientations. * Explore to what extent therapists of a given orientation endorse techniques outside of their orientation *To explore what techniques are endorsed across orientations.	*201 therapists	*Participants endorsed substantial frequencies of techniques from outside their respective orientations. * Many endorsed techniques were notably different from those of core theories of the respective orientations. *Results supported integration theories such as Werner's developmental theory, Implicit theory.	*US-based; Non-UK generalisable *Non-standardised questionnaires used. *Potential for sample bias and/or demand characteristics. *Study was limited in its inferences due to its exploratory. *Broad and descriptive nature. *Totally reliant on self-report *Small sample.

Nelson and Steele (2008) **Quantitative** *Online survey measuring practitioner attitudes to treatment selection. *Respondents were asked to rate influence of 29 potential considerations in treatment selection on likert scales *Participants were asked to rank their preferences among ten broad treatment considerations.	*To examine the importance of various considerations on practitioner treatment Selection.	*206 mental health professionals	*Results indicated practitioners were influenced by varying considerations including empirical evidence from applied field studies *Perceived flexibility of a treatment deemed important *The appeal of treatment to colleagues and clients was also influential.	*US-based; Non-UK generalisable. *Non-standardised questionnaires used. *Potential for sample bias and self-report bias, demand characteristics. * Representativeness of sample unknown.
Nelson and Steele (2007) **Quantitative** *National online survey *97 items assessing practitioners' professional characteristics, attitudes toward treatment research and EBT use.	*To report on EBT-use in mental health practitioners in an attempt to identify correlates of self-reported EBP use in practice.	*214 mental health practitioners from 15 US states recruited from diverse clinical settings and representing variable theoretical orientations.	*Results indicated clinician training, perceived openness of the clinical setting toward EBTs, and practitioner attitudes toward treatment research were significant predictors of self-reported EBP use. *Negative attitudes towards EBT research was found, and partially mediated the relationship between self-reported EBT use.	*US-based; Non-UK generalisable *Potential self-report biases - relationships observed between variables might be partially attributable to common-method variance. *Potential for social desirability bias. *Non-standardised questionnaire *Non-standard definition of EBT so practitioners may have used own definitions. *Representativeness of the sample unknown.

Berke, Rozell, Hogan, Norcross and Karpiak (2011) **Quantitative** *Surveys measuring *Practitioner frequency of engaging in EBT *Knowledge of 12 online research databases *Knowledge of 12 research methods and designs	*To assess clinical psychologists' knowledge of both online research resources and research methods central to the implementation of EBTs	*549 psychologists *Randomly selected sample of Society of Clinical Psychology (APA Division 12) members.	*Psychologists reported using EBTs in 73.1% of psychological services. *Apart from PsycINFO and MEDLINE, psychologists related low to moderate knowledge of online research resources. *Psychologists' theoretical orientation, clinical experience, and employment setting predicted knowledge of both online resources and research designs.	*US-based and psychologists registered with Society of Clinical Psychology *Non-UK generalisable *Sample bias; mostly older clinicians *Potential presence of self-report biases. *Non-standardised measures *No independent means of assessing knowledge EBT-use.
Jensen-Doss, Hawley, Lopez, Ostenberg (2009). **Quantitative:** *Self-report surveys *The Provider Attitudes Toward EBTs scale. *The second scale, Colleague Attitudes Toward EBTs *The Agency Support for Implementation Scale *The Barriers to Implementation Scale	*To assess experiences of children's mental health workers working under an EBT Mandate	*197 mental health workers working in children's settings.	*Providers' attitudes toward EBTs and their perceptions of their colleagues' support for the EBTs were negative. *Significant, independent predictors of providers' attitudes towards EBTs included: views of their colleagues', workplace support for EBT, opinions of the quality of their training in the EBTs, research and perception of institutional barriers to EBT-use *Practitioners identified a need to deviate from EBT models to meet clients' needs appropriately. Evidence of judgement about clinical complexity. *Practitioners generally found EBTs made individualised care difficult for children and families. *Less experienced practitioners valued and used EBTs less *25% of sample said they used EBTs with less than 75% of their clients.	*US-based; Non-UK generalisable. *Self-report bias *Potential presence of demand characteristics on results *Demographic data not presented; prohibits some comparative analyses. *Although providers reported usage of EBTs, fidelity or competence was not measured. *Surveys have limited scope to explore complex phenomenon like the implementation of EBTs. *Non-standardised scales

Appendix 3: Semi-structured interview

Thank you for taking part in this interview. As you know I am doing my MRP on therapist adherence to therapeutic models. So this interview will include questions relating to you opinions on this as well as your clinical practice. Please note that this is an exploratory project and I am only interested in your opinion, there are no right or wrong answers. You are under no obligation to answer any of the questions, and if you would prefer not to answer *any, then please don't hesitate to say so.*

Gender: Age: Job title: Years qualified:

1)   So that I can understand a little about the way you prefer to practice therapy, could you please describe your therapeutic approach and theoretic orientation? (Prompts: What model do you prefer to practice in? What type of clients do you work with?)

2)   What do you understand about the term "model fidelity" or model adherence? (Prompt: How would you define?)

3)   Can you explain how you feel about adherence to models in a therapeutic setting? How important do you feel adherence is in your own practice?

4)   Do you feel adherence is more appropriate/ necessary for certain types of work, when using certain models, treating certain problems? If so, why?

5)   If you practice using differing models, does your tendency to adhere differ? Why?

6)   How do you personally value adherence to models? What do you believe has affected the way you value adherence to model?

7)   Are there any circumstances that you believe adherence to models is/was more or less useful? Why do you think this?

8)   Since you have been practising, have your opinions about adherence to model altered? If so how and why?

9)   What do you feel are the biggest factors that have lead to your preferred method of clinical practice or theoretic orientation?

10) What do you think and feel about the role of evidence-based treatments, research and RCTs in mental health?

11) We've talked a lot about adherence to models, but is there anything else that therapists should adhere to in your opinion?

Appendix 4: NHS trust Research and Development approval

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Appendix 5: Participant consent form

CONSENT FORM

Title of Project: Adherence to therapeutic Models: What do therapists understand by adherence?

Name of Researcher: Stefan Peart

Researcher Contact details:	

Participant Contact details:	

This is a consent form requesting your consent to use data you provide as part of an Independent Research Project.

As an informed participant, I understand that:

1. My participation is voluntary and I may cease to take part at any time, without penalty.
2. All information I provide will remain anonymous; no record of my name or any personal information will be used or will be identifiable at any time.

3. I am aware of what my participation involves.

4. There are no risks involved in the participation of this study.

5. Information I provide retained for the researcher's convenience only. It will be anonymised, stored electronically and password protected.

6. I have read and understood the information sheet

7. I am aware that if I divulge any clinical practice that deviates from the clinician code of ethics, the researcher is obligated to report this to the relevant professional body.

8. All my questions about the research and my participation have been satisfactorily answered.

Please initial box

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

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

3. I understand that any personal information that I provide to the researchers will be kept strictly confidential

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

_____   _____   _____

Name of Participant   Date   Signature

_____   _____   _____

Name of Person taking consent   Date   Signature

(if different from researcher)

_____   _____   _____

Researcher   Date   Signature

Copies: 1 for participant

              1 for researcher

Appendix 6: Participant information sheet

TITLE OF RESEARCH PROJECT

<u>PARTICIPANT INFORMATION SHEET</u>

A research study is being sponsored by the Department of Applied Psychology at Canterbury Christ Church University (CCCU) by Stefan Peart (Trainee Clinical Psychologist).

Background

Thank you for considering taking part in this Major Research Project for a Clinical Psychology Doctorate programme at Canterbury and Christ Church University, Salomons Campus.

Research has shown that therapists differ markedly in the way they value adherence to technique and model protocol when performing therapy. Some research has suggested that model/technique adherence is beneficial for positive therapeutic outcome, while other research has found that adherence does not mediate therapeutic gain and that deviating from model protocol is beneficial.

This research aims to explore how therapists relate to the concept of adherence to gain a better understanding of the construct, with particular emphasis on the way in which therapists value adherence, their relationship to adherence and their personal and professional opinions on adherence.

The content of the interview relates to therapist opinion and practice regarding adherence and no personal or sensitive information will be sought. However, please be aware that in the unlikely event that a participant informs the researcher of clinical practice that deviates from the clinician code of ethical practice, I am obligated to report this to the relevant professional body.

<u>**What will you be required to do?**</u>

I will be conducting a face-to-face interview with consenting therapists, asking a variety of questions relating to adherence. The interview should last no longer than 30 minutes.

Procedures

Be available for a face-to-face interview with the researcher at a place of your convenience. The interview will last for approximately 30 minutes.

Feedback

Feedback about the results will be made available to participants via letter, following the completion of the research.

Confidentiality

Interviews will be recorded for convenience, but no identifiable information on the recording will be traceable to any therapist participating. Additionally, only the researchers conducting this project will have access to the recordings and, following the completion of the project, no copies of the recording will be kept. All data and personal information will be stored securely within CCCU premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. Data can only be accessed by Stefan Peart. All data will be made anonymous (i.e. all personal information associated with the data will be removed).

Dissemination of results

The researcher aims to publish the results in a peer-reviewed journal, and all participants will be alerted if publication is successful.

Deciding whether to participate

If you have any questions or concerns about the nature, procedures or requirements for participation do not hesitate to contact me. Should you decide to participate, you will be free to withdraw at any time without having to give a reason.

Any questions?

Please contact the researcher with any queries.

Stefan Peart

Canterbury and Christ Chrurch University

Salomons Campus at Tunbridge Wells

Broomhill Road

Southborough

Kent

TN3 OTG

Appendix 7: Sample memos from emerging categories

Emerging category: Containment

There is a theme arising around psychologists feeling that model fidelity is a means of reducing anxiety when training. Most of the comments in relation to times when model fidelity is deemed most useful have referred to feelings of safety. Participants 2, 6 and 7 described it feeling safer for them but also for their clients. I am wondering what links a 'sense of incompetency' may have with model fidelity. It would seem from the interviews so far that model fidelity might be deemed of most use as a means of controlling a sense of incompetency. This could link in with experience but also seems to be about wanting to do the right thing when starting training. I am wondering if it's about wanting to be seen to do the right thing by superiors by following a model efficiently, or if it's more to do with wanting to do the right thing for the people they are doing therapy with. Further probing on this will be useful in future interviews.

Emerging category: beliefs about change

Open coding is producing themes around changing beliefs about the ingredients of therapy. I was interested in the language participant 5 used to describe her beliefs about the function of model adherence when she began, suggesting she thought it would "cure". Curing evokes connotations about a medicalised view to therapy. I am wondering how much this medicalised belief impacts model use and what it was that then altered this view? There seems to be something coming up about a tendency to believe that models were the things that changed people when they began training. I wonder at what stage psychologists started to realise their own role and their clients' roles in the change process and what impact this had on model fidelity.

There has been quite a few references made to psychologists believing that psychotherapy models were distinct entities when they began training and how this seemed to change over time. This ties in with the beliefs about the ingredients of therapy models and might infer that fidelity was seen as more important at the start of training because otherwise therapy would be ineffective.

Emerging category: Fitting people into models

Participants have been referring to fitting their clients into templates of models when they started training. I am wondering how much this is linked to model fidelity. Were they trying to fit people into models to adhere to the model, or were they doing it because they did not know how else to treat people? This will need further exploration in subsequent interviews. There are ideas coming up about a faith in prescriptive forms of therapy as a treatment early on; about fitting a treatment model to a client's diagnosis perhaps? If this treatment can be offered to everyone with a shared diagnosis? I am interested in addressing whether and when psychologists might have identified the commonalities among some treatments, or perhaps if they still prefer to think of each treatment model as a discrete entity.

Emerging category: Encountering clinical complexity

Complexity keeps arising in discussions. There seems to be something about psychologists being protected from complexity during early stages of training and then, as one participant put it, "reality bites" when they start to practice. It would seem from this then that complexity was a changing factor in the way psychologists conceptualised model fidelity. From many discussions, it appeared that clinical complexity threw a bit of a spanner in the works, and they had to adapt the way the practiced to make the treatment helpful for their clients. I am interested to know more about the way psychologists define complexity and how it actually altered the way they practice. There are certainly references to some sort of evolutionary factors upon practice that merits further thought.

Emerging category: Discovering value in integration or eclectism

Many of the psychologists consider themselves integrative and I am wondering what influenced their stance on model use, whether it was because they found it limiting to use only one model from a professional view-point, or because it was unhelpful for their clients. Some have discussed the value in integration or eclectic models as a means to respond to complexity, which would suggest that in such instances practice needed to be adapted in some way. This theme about experimenting with integration seems to be a part of an evolutionary process away from model fidelity. I would be interested to know more about participants' experiences with integrative and eclectic methods.

Emerging category: Adhering to the person

As the interviews progress, I am starting to see a pattern emerging in relation to the use of models, and distinct stages are appearing. There is a lot of discussion about what seems to me to be an evolution away from model-centred approaches when psychologists gain experience, to becoming adherent to something else more person specific. Perhaps something about adhering to the individual? This stage of the process would not necessarily preclude model fidelity, but this is not as prescriptive or systematic in the reason for it being offered, as it appeared to be during the early stages of clinical practice. There is much more focus discussed about the therapeutic relationship and other person centred skills and their importance to therapy than was referred to previously.

Emerging category: Identifying common factors in models

Lots of discussion cropping up about what is the same about models, and the overlapping processes of models that psychologists appear to believe developed with experience. It would seem that being able to understand what's similar is held in high regard as a skill by most of the psychologists who spoke of it. I am wondering how this affected participants' beliefs about what creates change in therapy....If models have core similarities, what are the consequences to practice: does it mean that distinct models are deemed unnecessary? And what are these common factors and why are they deemed useful in a therapeutic sense? I also wonder how much each distinct stage that is forming is necessary as part of a growth journey as a psychologist. It would seem that, in order to know there are common factors for instance, one would have to have experience with models in the first place. What is model fidelity's role in helping psychologists identify similarities?

Emerging category: Ambivalent relationship with fidelity

Interestingly there seems to be a rhetoric surrounding feelings of guilt about not adhering after qualifying. I am wondering about the links between this and pressure to adhere to evidence based practices, whether this might be impacting upon participants' unease. Participants seemed to be generally quite ambivalent towards model fidelity and research at this stage. Although it is universally accepted that research and evidence is important, there seem to be more questioning of research findings that correlates with experience. I am wondering if that's part of the critical skills that psychologists gain as part of training. Perhaps they have learnt to be more critical of research, but perhaps it's incongruence between research and practice experience that has lead to the ambivalence? Nevertheless, this seems to have made no impact upon practice, because even though there is guilt involved for some, they do not adhere to models if that does not fit their clients. It seems to be a conundrum between doing what works for their clients and doing what is expected from their practice. I am interested to enquire specifically about opinions on the role of research in clinical practice.

Appendix 8: Canterbury Christ Church University (Salomons) Ethics approval letter

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Appendix 10: Code of conduct cross-checks

This research was checked to comply to

- The British Psychological Society Code of Conduct (2006)
- The Data Protection Act (1998)
- The Freedom of Information Act (2000)
- The NHS confidentiality code of practice (2003)
- The Health Professionals Council (HPC, 2009) code of ethics and conduct.

Appendix 11: Abridged table of categories

Quotations from interviews	Open coding	Subcategories (Axial coding)	Intermediate categories (Selective coding)	Highest-order category (Selective coding)
"If one is newer to psychological therapies, it is probably safer for the client if the therapist adheres to a protocol"	fidelity as a safety net	containment	Intermediate category 1. model-centred practice - generic understanding of needs	Internal drivers to meet needs
"Having a protocol and model to adhere to made me feel less anxious when I started training"	Anxiety reducing		model-centred practice - generic understanding of needs	
"something reassuring about having permission to only use one model"	Fidelity reassuring			

"When I started training I believed that all models were fundamentally different"	Segregated models	beliefs about change	model-centred practice - generic understanding of needs	Internal drivers to meet needs
"I used to believe that if I sort of followed CBT precisely for certain problems like panic or OCD, a person could be 'cured' of their problem."	Fidelity can fix the problem			
"I may have been guilty of cookie-cutter therapy when I began, giving everyone the same treatment because that's what the service permitted and I was too inexperienced to question it. I think I was making the person 'fit' the model, rather than making the way I worked fit the person".	Generic treatment	Fitting people into models	model-centred practice - generic understanding of needs	
"I remember following principles, techniques set out by models quite diligently when I started [...] reflecting on my work then feels quite prescriptive to me, sort of like fitting people into nice neat little boxes and"	Prescriptive therapy	Fitting people into models		

"When I trained, particular placements involved working with one model over others and I think that's a helpful way of embedding learning,"	Fidelity embeds skills	Learning and competency	model-centred practice - generic understanding of needs	
"So my experiences of model adherence as learning or teaching aids have been positive."	Fidelity teaches			
"I preferred actually being taught in purest way and being able to use it as myself and being able to be able to provide my own unique therapy and tailor the bits that I want"	Pure form learning enables eclectic practice	Learning and competency		Internal drivers to meet needs
"I realised that cognitive behavioural models don't explain the entirety of human behaviour."	Realisation of complexity	Encountering clinical complexity	Intermediate category 2: Evolving practice – revaluating how to meet needs	
"It soon dawned on me that fidelity is really hard to do in the real world as models don't allow for the wide scale differences seen in humans. My clients have complex problems that require a				

flexible and creative response and limiting myself to one paradigm takes away options and would be ineffective"	Not being able to standardise people			
Over time I began to see the benefits of different models. Things weren't so distinct for me. [...] With complex cases, where there are longstanding relational problems, the therapeutic relationship is tested, the system is more stuck, you need as many lenses as possible to help you think and find ways of relating. I don't feel it's so helpful to feel like thinking needs to be informed by only one model".	Complexity is helped by integration	Discovering value in integration or eclectism	Evolving practice – revaluating how to meet needs	Internal drivers to meet needs
"I feel a bit more able to be flexible in my approach since qualifying."	Confident to be flexible	Confidence to experiment		
"I started to take risks in my practice when I started to question what I was really adhering to"	More comfortable with uncertainty			

There's something else in between theory and practice. I believe it's something to do with what the therapist picks up about clients from one moment to the next.	Covert communications/mentalisation	developing intuition	Evolving practice – revaluating how to meet needs	Internal drivers to meet needs
"Some days my clients will need something structured, some days less structured. They wont always say, but you develop a feel for what is right because of the therapeutic relationship."	Using the relationship to understand client's communication			
I think strict model adherence could result in attempts to make the person 'fit' the model, rather than making the way we work fit the person.	Tailoring therapy to the person	Adhering to the person.	Intermediate category 3: person-centred practice - individualistic understanding of needs	
"Tailor therapy to the individual, so the kind of values I employ and how I relate to the person. I think I genuinely try to adhere to	Making treatment individualistic			

person-centred values"			person-centred practice - individualistic understanding of needs	
"I want to help ease people's distress and I am not too precious to avoid using certain approaches if they haven't been combined into a pre-existing treatment methodology. When choosing an approach I'd be thinking about suitability and what would work for that person"	Person is more important than models			
I was trained to use and formulate using multiple models When working with clients that face multi-faceted adversity it is often useful to have more than one way of understanding the difficulties	Training emphasises multiple models Different models give different lenses	Multi-perspective understanding	person-centred practice - individualistic understanding of needs	Internal drivers to meet needs

adhering to protocols should never override other process factors as this can result in a rigid and sterile environment	Processes are more important than adherence to models	Changing awareness of therapeutic processes	person-centred practice - individualistic understanding of needs	Internal drivers to meet needs
Empathy, warmth, the ability to understand clients' thoughts, communications, hopes and goals are essential components of the therapeutic relationship	Awareness that the therapeutic relationship is essential to treatment's success.			
Mechanisms of change may not be as different or under our control as we think	Awareness of unquantifiable change processes		person-centred practice - individualistic understanding of needs	

mentalisation [...] is probably the most essential skill required to be a therapist and it transgresses all therapeutic modalities	Most important factor in therapies a common factors to all models	Identifying common factors in models	person-centred practice - individualistic understanding of needs	Internal drivers to meet needs
Over time you form certain beliefs about change in therapy, you see what different models have to contribute to that, you realise the overlaps in the underlying theories of change, and you think and practice more flexibly.	Distinct to seeing overlapping elements to models			
In different ways, different models look to reframe the presenting problem; they give it a different context and meaning.	Shared goals, to understand clients			Internal drivers to meet needs
I question adherence to specific models [...] what are we constructing? What are we obfuscating? Why am I attending to certain things and not others? What discourses are informin	Querying why one adheres. A meta position on adherence	Ambivalence towards model fidelity	Ambivalent relationship with fidelity	

So it's not that I don't value adherence, it's that I worry that if taken to extremes, it comes at the expense of thoughtfulness, that it prioritises your agenda, and that it can get in between you and the client.	Adherence can be an obstacle	Ambivalence towards model fidelity		
Fidelity is only useful if you have clients that can follow a model and understand it, and therefore they must not have very complex difficulties and they have to be receptive to listing as opposed to constantly needing to speak. So basically, they have to have one problem and be in the normal range and be quite intelligent, they have to be receptive to information, not just receptive to being listened to. That's an ideal	Realisation that fidelity is useful in some cases, but not in all.	Ambivalence towards model fidelity	Ambivalent relationship with fidelity	Internal drivers to meet needs
I think we have become too obsessed by the evidence-base, and I am slightly sceptical when it is for interventions about economic efficiency that often produce good-looking short-term results at the	Scepticism regarding research	Ambivalence towards research		

expense of making a long-term difference to people's lives.We need research to test the boundaries. We just need to find ways of researching that are more innovative and inclusive than we currently have.	Research is not measuring the right things currently			Internal drivers to meet needs
I worry RCTs give an idea that therapy can be completely controlled, prescribed and will work the same for all people with a specific disorder, almost like a drug	RCTs a medicalised approach to research	Ambivalence towards research		
I don't do and it makes me feel guilty, because it makes me feel that I'm not as good a psychologist as other people;	Guilt regarding non-adherence	Expectation to adhere versus practice	Ambivalent relationship with fidelity	
however, then I talk to my colleagues and realise that they				

don't adhere to specific models either and that makes me feel better	Unrevised practice			Internal drivers to meet needs
if I just used Beckian CBT with my clients I'd be missing a trick and not paying full service to their situation so I use other approaches as well. I am possibly more scornful than is absolutely necessary about people who can be therapeutically pure and make it work [...] I doubt my ability to do this.	Questions ability to adhere	Expectation to adhere versus practice		

Appendix 12: Uncoded transcript

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Appendix 13: Research diary

January 2010

The research fair at Salomons today gave some really interesting presentations and ideas for my MRP. Lots to consider. It's made me realise that I need to be thinking about the project I want to be doing already so I will try and put some of my ideas down on paper so that I can feel like the brain-storming part of the process is underway.

April 2010

Having hit a hurdle with my initial research project, it is looking like it won't be able to go ahead at this stage due to a shortage of data. I have met with my supervisor to discuss some other possible ideas and am quite intrigued by one about therapists and model adherence. The notion of psychologists practicing fidelity to one model has always interested me. I had only recently been discussing with a placement supervisor the role of manualised therapies in clinical psychology, and that evoked some interesting discussion about the value in multi-model training psychologists receive. I am drawn to the idea of researching model adherence, and so will think of a route around that.

January 2011

Having decided to do an exploratory study on model fidelity in therapists, I am now at the stage where I need to consider ethics. It seems that, even though I am only using practitioners and not service users, I may still need to submit a NRES ethics application because I am using NHS staff. This seems like a laborious task and I have lots of other coursework to do. It feels a little like putting out fires at the moment, but will need to get around to completing the application soon so I can begin recruitment and interviewing. I am aware that other trainees are already past this stage of the process and I am feeling a little behind.

May 2011

I have been quite dormant on the MRP front for several months while I finished other work and still have yet to submit an NRES application. I am aware that I am stalling this process for some reason, so I am going to make a big effort to push past this and get this done over the next month or so, so that I can feel like I am doing something.

July 2011

Having finally completed my NRES application form, which took ages, I contacted NRES about submitting the form only to be told that rules had been changed very recently and research recruiting NHS staff now did not need NRES approval! So, I have wasted a huge chunk of time procrastinating doing the NRES form, then completing the NRES form, when I could have already been interviewing and recruiting. Very frustrating! I am also struggling to get approval from the NHS trust's R&D department from which I want to recruit. I was informed that my research would likely be approved, but no confirmation certificate has yet arrived and my emails are being ignored or not auctioned. Frustrating process, but have no choice but to continue contacting the department. I hope that their inactivity is more about them being busy than about there being something wrong with my MRP.

September 2011
I am in the midst of interviewing. I haven't had too much trouble recruiting so far, but the difficulty has been tallying my schedule and study days with participants' working diaries. People are very busy and it's making interviewing quite a slow process. I may need to think about taking annual leave from placement in order to do the interviews.

December 2011
I have been transcribing some of the interviews; it's quite a laborious process but it's definitely helping me to come up with ideas for coding and categories. The thing that is striking me most in the transcription is psychologists' ambivalence towards model fidelity. I have not found anyone totally for or totally against fidelity; it is really seeming to depend on the person and what's needed, but something is coming up in relation to the way participants' reflect the change in their stance towards fidelity. I had considered using a professional transcriber as I doubted my patience with transcribing my own interviews. I am pleased I didn't go down that route because I am learning much more about the data by doing it myself. Ideas are coming to me that were not so evident during the interview, and it's giving me thoughts about things to include in upcoming interviews.

March 2012
I am in the process of finishing off my interviews and hoped to get them done before Easter. Writing up of section A is a lot harder than I imagined. I am ploughing through lots of literature and there are so many ways I could potentially take the literature review. Too many ideas and I will need to think strategically about how I want to present the review. I could quite easily go off track and I only have a small number of words.

April 2012
I have run my plan for section A past my supervisor John and he seems to think I am on the right track, so I feel a little more confident about writing this now. It feels a big task, almost like a piece of research by itself due to all the synthesis necessary.

August 2012
It has been a while since I have written anything in the diary or done anything in relation to my research because I was forced to take an extended break from the course due to unavoidable family circumstances and bereavement. Suffice to say that research-related things have felt so unimportant in the grand scheme of things given my recent circumstances. I have had to defer submission of my MRP, which was originally due in during July. I now feel somewhat 'lost at sea' with the project and have no idea how to pick myself back up and get myself motivated to continue the research.

October 2012
It is only really now that I have felt able to start thinking about research related things again. It's been a tough process getting back into it, but I have started reading over what I had written before the forced break and have arranged some more interviews with colleagues. It almost feels a little like starting again with the research and the section A. I have forgotten almost everything I already did in the interim. I am hoping that it starts to feel a little easier soon.

January 2013

With all my interviews done and my section A complete, I feel like I am finally getting somewhere with the research. I had hoped to feel more euphoric once I got section A finished, but am quickly realising it's just a drop in the ocean! Need to keep up the momentum and get a draft of section B done asap.

February 2013

Analysis was quite a journey. It was quite easy to feel lost in all the data at first, and getting to grips with grounded theory wasn't as easy as I'd hoped initially. I think I was starting out desperately trying to generate a theory from the outset, as I am using grounded theory analysis. I think this stopped me seeing the bigger picture. I took some advice from colleagues who have used the approach, and was relieved to hear that they went through a similar experience of despair. I needed to just relax with the data, and digest it and theory would generate naturally by itself. I am happy with the eventual model and theory I came up with and have had good feedback from my supervisor so I am feeling OK about things.

March 2013

Getting ready for submission. Scared and apprehensive. Not sure if I have done enough to pass, but it's too late to consider that now. Am realising that doing appendices is an incredibly time-consuming part of the MRP. Am relieved to have this finished and ready for submission and now am just hopeful that the examiners will think it is a sound piece of research.

Appendix 14: Summary of findings for participants and Salomons ethics panel

Dear study participants,

Between September 2011 and February 2013, you kindly agreed to participate in my research project about model fidelity in therapeutic practice. I greatly appreciate the time you gave up to be interviewed for the research and valued all off your contributions. Thank you very much. As we discussed after the interview, I am writing to inform you about the outcome of the study, which I hope to publish in due course.

Study title: A grounded theory of model fidelity in clinical psychologists' therapeutic practice

Rationale for the study: Impetus for mental-health settings to employ evidence-based therapies (EBTs) is increasing, but given the complexities involved in therapeutic processes, questions regarding the applicability and feasibility of model fidelity have been posed. Model fidelity might be a pertinent issue for clinical psychologists, who by nature of training are exposed to numerous therapeutic models. Therapists' relationship with practice is complex and may be shaped by multifaceted combinations of attitudes, values and development; however, little is known about how psychotherapies are implemented in practice, how therapists value and adhere to models and how this evolves over time. Furthermore, there is a paucity of empirical research exploring clinicians' practice wisdom. Given the prominence of fidelity to EBTs in mainstream therapeutic practice, a need has been highlighted for more empirical focus on practice wisdom to understand adaptations of interventions.

Method: A grounded theory was developed from semi-structured interviews conducted with thirteen Clinical psychologists. Each participant was interviewed about their attitudes and use of models, about their opinions and experiences about model fidelity and about the role of research in practice. All interviews were digitally recorded, transcribed and analysed. Analysis using Grounded Theory approaches involved coding of transcribed data and constant comparison between emerging categories or themes in the data.

Results: The grounded theory suggested that clinical psychologists' had evolving relationships with model fidelity. Practice was driven by a desire to meet the needs of those they treated therapeutically. Approaches to achieve this altered with experience. Inexperienced psychologists showed a tendency towards model-centered practice, a stage signifying generic or formulaic understanding of clients 'needs. Practice evolved to more person-centered approaches where psychologists no longer dogmatically adhered to models rather they adhered to each person in an idiosyncratic fashion and adapted treatment to suit. Factors affecting evolution included clinical intuition, ability to recognise processes of therapeutic change, to identify similarities between models and to integrate or practice eclectically. The evolutionary process elicited a more critical and reflective stance towards model-use and ambivalence towards the role of research-based models in clinical practice. This can be seen to corroborate the already often-cited "research to practice gap".

Implications of the study

The research implied that more resources may need to be invested into researching practice-based wisdom as a means to understanding therapeutic processes; Clinical psychologists, who have eclectic research skills, are well-positioned to participate in this process. It is my hope that the findings will enable better understanding about the relationship between model fidelity and therapeutic work and that further research either corroborating or taking the research forward will be possible.

Please do not hesitate to contact me should you want any more information about the study. I would be happy to send you a copy of the full report once the assessment process is complete and the report us finalised.

Much thanks for your time and participation.

Yours sincerely,

Stefan Peart
Trainee Clinical Psychologist
Salomons at Canterbury Christ Church University

Cc: Salomons Research Ethics Panel
   NHS Trust R & D department

Appendix 15: Psychology and Psychotherapy: Theory, Research and Practice publishing guidance

Psychology and Psychotherapy: Theory, Research and Practice

Edited By: Andrew Gumley and Matthias Schwannauer

Author Guidelines

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.

Word limits for specific article types are as follows:

• Research articles: 5000 words
• Qualitative papers: 6000 words
• Review papers: 6000 words
• Special Issue papers: 5000 words

3. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

4. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/paptrap/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

5. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded here.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

• For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

• All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

• Manuscripts describing clinical trials must be submitted in accordance with the CONSORT statement on reporting randomised controlled trials (http://www.consort-statement.org).

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

6. Multiple or Linked submissions

Authors considering submitting two or more linked submissions should discuss this with the Editors in the first instance.

7. Supporting Information

PAPT is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at http://authorservices.wiley.com/bauthor/suppmat.asp

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9. Colour illustrations

Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded **here**.

10. Pre-submission English-language editing

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