Seeking to improve cognitive behavioural therapy delivery in the NHS through the practical application of outcome predictors and therapist development

By

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Thesis Summary

The PhD in Professional Practice (Canterbury Christ Church University, 2014) is a service focused research programme, designed to investigate how psychological and research principles can be applied to a practical setting. The programme differs from a traditional PhD programme in that it requires that multiple approaches are taken to research on a common theme, each applying a different theoretical approach or addressing a different aspect of the subject. Within this context, the purpose of this thesis is to investigate the delivery of Cognitive Behavioural Therapy (CBT), within a large National Health Service Mental Health Foundation Trust in the United Kingdom, with a focus on possible ways of making that delivery more effective. Drawing on the author's experience as a therapist, trainer and leader in CBT services in the aforementioned Trust the thesis focuses primarily (though not exclusively) on the implementation of CBT in the Improving Access to Psychotherapies (IAPT) service that the author came to lead over the course of the PhD programme.

The thesis is divided into two distinct sections. Section 1 (Chapters 2 and 3) focuses on the prediction of therapy outcomes for CBT treatment of common anxiety and depressive disorders as may be applied to an IAPT service, and the possible practical applications of these. Chapter 2 is a critical review of the existing literature relating to clients' nonclinical pre-treatment psychological profiles and attitudes towards individual face to face CBT. It identified five factors that may predict outcomes; client personality traits, expectancy for/credibility of therapy, clients' interpersonal style, beliefs about illness, and preference for treatment. Evidence for each of these factors was mixed, with only client personality consistently predicting outcomes in all studies that it was investigated. Client motivation and dysfunctional attitudes were also identified as having good evidence for prediction based on previous reviews of the subjects. The review also explored CBT specific factors, such as an ability to recognise unbidden thinking (negative automatic thoughts (Beck et al., 1979) or differentiate between emotional states, through an investigation of multifactor tools for predicting client suitability for CBT. Only the Suitability for Short Term Cognitive Therapy Scale (SSCT) (Safran et al. 1993) showed consistent predictive validity for client outcomes over a number of studies, although which aspects of the SSCT are predictive remains unclear (Mhyr et al., 2007, Renaud et al., 2014). Chapter 3

consists of an examination of the predictive validity and factor structure of an existing pre-treatment self-report questionnaire that makes use of some of the above factors, to attempt to predict who would benefit most from receiving CBT. The Suitability for Cognitive Behaviour Therapy Scale (CBT-Suits) (McLellan et al., 2016), had previously demonstrated a good factor structure in existing literature and shows promise as a cost effective easy to use tool for aiding in clinical assessments of need in CBT (McLellan et al., 2016; McLellan et al., 2019). The factor structure and predictive validity of the CBT-Suits were investigated using data from participants attending the participating IAPT service for CBT for anxiety and depressive disorders. The CBT-Suits demonstrated good factor structure in confirmatory factor analysis but did not demonstrate any predictive validity for outcomes over and above that provided by initial symptom severity. Implications of this are discussed.

The client is not the only participant in therapy however and the quality of the therapy provided can also correlate significantly with client outcomes (Simons et al., 2000; Westbrook et al., 2008). In addition to the critical review of literature and investigative research projects, the PhD in Professional Practice requires the completion of two other studies, a smaller scale service related project, designed to improve the quality of services in the author's field of work, and a more personal study based on their own practice.

Section 2 (Chapters 4 and 5) of this thesis incorporates both the service related project and the report of professional practice for this PhD programme. As Section 1 focused on how client predictors of therapy outcome might be utilised to improve the quality of CBT provision, Section 2 addresses the subject of therapist competence, focusing on both the evaluation, and practical challenges of providing therapist training and development in a clinical NHS setting. Chapter 3 evaluates a CBT training and supervision programme for junior doctors undergoing Core Psychiatry training with the Royal College of Psychiatry (Royal College of Psychiatrists, 2015). This training and supervision programme was required to teach doctors with little to no previous experience of CBT to adequately provide a course of CBT treatment to a member of the public with clinical symptoms of anxiety and/or depression. It explores the issues faced and successes achieved by the group as they undertake their first clinical CBT case and evaluates the support and training that they were offered. Evaluations

of the programme revealed that it was universally well liked and regarded by the trainees as adding significantly to their competence. Amendments to the programme based on the feedback are discussed. The final substantive chapter of the portfolio (Chapter 5) approaches the subject of therapist development from the opposite end of the spectrum by exploring the experiences of a skilled CBT therapist and trainer (the author) when undertaking an evidence based Continuing Practice and Development (CPD) programme for CBT therapists known as Self Practice and Self Reflection (SPSR) (Bennett-Levy et al., 2001). As with Chapter 3, the primary aim of this chapter is not to evaluate any direct relationship between undertaking the programme and clinical outcomes, but rather to investigate its applicability in a busy clinical setting, exploring not only the perceived benefits of undertaking such a programme, but also the struggles and stresses placed on both services and the individual engaging in it. The SPSR programme was broadly helpful in enabling the therapist to address their concerns about their CBT practice, and highlight and address areas of therapist drift (Waller, 2009), in which their competence as a therapist had deviated from the evidence based best practice. However, the programme was challenging and the therapist found it difficult to prioritise CPD completion alongside their clinical practice, particularly in the context of the Covid-19 pandemic. Reflections are made on the balance between a focus on competence development at the possible cost to service delivery for therapists who already meet the required competences to provide effective therapy.

Taken as a whole this thesis addresses the question of how can what we know about the people attending for CBT, and those providing CBT be utilised practically to improve the quality of therapy provided by NHS services. Section 1 asks the question “what do we know about who is likely to benefit from CBT and can we use this to improve the therapy they receive?”, and Section 2 asks “How can we improve the competence of therapists, in the most effective way, without detracting from the service provided?", and “how do we balance the conflicting demands of therapist development and service delivery?”. Taken together it is hoped that this knowledge can be applied to the delivery of CBT services, in order to provide the most clinically effective treatments in the most efficient manner.

Contents

Chapter 1

Introduction to the Thesis

Requirements of the PhD in Professional Practice: Psychological Perspectives

The PhD in professional practice requires a portfolio thesis comprising of four chapters, each addressing the topic of the thesis from a different perspective. These are a critical review of the existing literature surrounding one or more aspects of the thesis subject; an investigative research project that constitutes an original contribution to the knowledge base in the field; a service related research project or evaluation designed to enhance practice related aspect of the authors professional role; and a study focused on a specific aspect of the author's professional work, providing the opportunity for reflections and learning related to their work practices (Canterbury Christ Church University, 2014). In order to gain the broadest experience from the programme the author has utilised a variety of research methods designs across the component studies of the thesis. Section 1 utilises a primarily quantitative design, whilst section 2 draws more heavily on mixed methodology and qualitative research methods.

Thesis purpose and context

This PhD in professional practice draws on the author's 14 years providing CBT in the NHS, first as a therapist, then a trainer and finally as a service leader. It was motivated by observations on the way that services have been implemented during that time and a desire to improve the way CBT is offered in the NHS, in terms of both the quality of clinical delivery and the efficiency of services. This latter is particularly important given concerns about funding of mental health services in the United Kingdom (UK), which has historically been significantly below that of funding for physical health conditions and that which is required for the assessed level of need (Kings Fund, 2015). According to the Kings Fund (2015) the treatment of mental health conditions made up 23% of the overall workload of the NHS in the 2014/15 period, whilst only receiving 15% of the funding. Whilst the Government has pledged to bring "parity of esteem" to mental health conditions in the NHS (Department of Health, 2011a; p.2), funding for mental health services remains a significant point of

discussion amongst NHS professionals (British Medical Association (2020), Government (Department of Health and Social Care, 2021b) and society as a whole (Lay, 2020). At first glance it might appear that CBT treatment is one of the better funded areas of the NHS. As the primary treatment offered by IAPT services (National Collaborating Centre for Mental Health, 2021), the implementation of CBT has become widely available on the NHS, with the government earmarking an additional £173 million pounds to primary care psychotherapy to fund the national IAPT roll out in 2007 (BBC news, 2009). However, earmarking is not ring-fencing, and payments for IAPT services are dependent on contracting with individual Care Commissioning Groups (National Health Service for England, 2021), resulting in differences in payments from one area to another. The subject of funding also needs to be seen in the context of expected levels of service delivery. IAPT services are expected to see 25% of all eligible sufferers of depressive and anxiety disorders in 2020/21 in England, an estimated 1.6 million people (National Health Service, 2021). If the NHS is to meet its stated principles of making "the most effective, fair and sustainable use of finite resources" (Department of Health and Social Care, 2021a), it is important that services are provided as effectively as possible, both in terms of cost and in ensuring that recipients of therapy receive the most effective treatment for their needs.

In order to begin to address these issues, this thesis aims to explore the practical applications of research that may be used to improve CBT services in NHS settings from two perspectives. Section 1 (comprising of the critical review of literature and investigative research project) explores the non-clinical client predictors of outcomes in CBT, in order to try and improve decision making processes regarding assessment of who is most likely to benefit from treatment, and how to support those who are likely to find therapy difficult. Section 2 (which comprises of both service and practice related studies) investigates ways of supporting professionals to improve the quality of therapy that they provide, through training and Continuing Practice and Development (CPD), within a busy clinical setting. Rather than purely exploring the efficacy of training in improving competence and outcomes (an area that has been broadly studied (Branson et al., 2105; Liness et al., 2019; Rakovshik & McManus, 2010; Simons et al., 2000; Westbrook et al., 2008), this section also focuses on the

practicalities of providing and undertaking such training, exploring the experiences of those undertaking it and the potential impact on service delivery.

Section 1

The first section of this thesis attempts to answer the question "what do we know about who is likely to benefit from CBT and how can we make use of this knowledge to improve service delivery?" by investigating the role of pre-treatment personality and attitudes to therapy expressed by people attending for CBT in predicting outcomes. As the review of literature will show, these factors have been investigated across a range of studies. However, research into the area frequently focuses only on a single or limited number of possible predictors. As such the cumulative knowledge in this area is limited to drawing from multiple studies, each of which shows only a single piece of the puzzle. Whilst there have been some reviews collating data on predictor studies conducted to date, these have been restrictive in terms of the scope of the predictors being measured (e.g., Keijsers et al., 2000) or in terms of the presenting problems being treated (e.g. Hamilton & Dobson, 2002).

Chapter 2

Chapter 2 of this thesis takes a more pragmatic approach than other reviews of the literature, focusing on the clinical population and treatment likely to be offered by NHS IAPT services at their highest level of need. It seeks to review the existing literature addressing pre-treatment psychological and attitudinal predictors of outcomes in CBT, from studies focusing solely on individual face to face therapy, for common mental health problems. This lays the groundwork for Chapter 3, which will investigate the practical applications of a tool designed to predict outcomes based on these factors in a UK IAPT setting.

Chapter 3

Chapter 3 of this thesis seeks to investigate a promising tool that may assist clinicians in assessing for suitability for CBT. The Suitability for CBT scale (CBT-Suits) (McLellan et al., 2016, McLellan et al., 2019) is a short, pre-treatment self-report questionnaire that attempts to predict

symptom severity outcomes in CBT. Whilst there are a limited number of published studies investigating the CBT-Suits it has shown a strong factor structure in non-clinical samples and has demonstrated predictive validity for outcomes in a study of group CBT for social phobia. However, the CBT-Suits has yet to be studied in IAPT services or for use with a "real world" clinical population in any published study. Chapter 3 investigates the factor structure and predictive validity of the CBT-Suits in an IAPT setting, with a view to assessing its utility for integration into initial assessments and CBT treatments. It is hoped that should the CBT-Suits demonstrate predictive validity for outcomes, over and above that provided by initial symptom severity it could be of benefit to service delivery by improving the sensitivity and accuracy of assessments of need, and potentially highlighting possible blocks in therapy.

Section 2

Section 1 of this thesis explores the possibility of improving the effectiveness of assessments of need and CBT treatment by attempting to predict who CBT would be most useful for and where blocks in therapy might occur. However, the client is not the only participant in the therapy process and the competence of the therapist can also influence the therapy outcomes (Waller, 2009). In order to ensure competence, UK CBT therapists undergo extensive training and assessment before they are accreditable as psychotherapists with the accrediting body for CBT in the UK, British Association for Behavioural and Cognitive Psychotherapies (BABCP) (British Association for Cognitive and Behavioural Psychotherapies, 2017). Similarly, qualified CBT therapists are required to undertake frequent continuing practice development (CPD) in order to maintain their accreditation (British Association for Cognitive and Behavioural Psychotherapies, 2017). However, training and practice development are not free, and their provision places a burden on hard pressed services in terms of training costs, salary and lost income (in payment by activity contracted services). They can also place a burden of stress on the individual undertaking the training (Bennett-Levy et al., 2003; Colford, 1989). As such it is important that both training and practice development are suited to both the individual and service sponsoring them, as well as being likely to achieve the desired effects.

Training, competence and outcomes – a complicated relationship

At first glance the relationships between training and competence, and competence and outcomes should be self-evident, but when the literature is explored in more detail a number of complications arise. The first issue that this subject throws up is that of how we determine competence itself. As with so many other aspects of this field there are differing perspectives on the definition of what competence is and how it can be measured (Barber et al., 2007; Kaslow et al., 2007; Kaslow et al., 2009). IAPT CBT psychotherapist training primarily uses a measure of competence based on a combination of theoretical assignments, case studies, and an experiential assessment of therapy sessions made by a qualified impartial observer, rated using a measure known as the Revised Cognitive Therapy Scale (CTS-R) (Blackburn et al., 2001). However, the predictive validity of the CTS-R with regard to client outcomes has not yet been assessed, and at least two studies of separate year-long CBT training programmes, (Branson et al., 2105; Liness et al., 2019) found that whilst therapist competence increased on their measures over the course of the training programme, this did not correspond with a significant increase in treatment outcomes. One argument to resolve this apparent discrepancy is to measure therapist's competence by treatment outcomes themselves. A number of studies have explored the relationship between therapist competence and outcomes directly, indicating that brief therapist training and supervision of novices in particular (Simons et al., 2000; Westbrook et al., 2008), can be related to significantly improved outcomes in CBT related treatments. It has been pointed however that to conflate competence directly with outcomes fails to take into account client related factors such as symptom severity or those discussed above or demographic and socio economic factors that might correlate with outcomes (Rakovshik & McManus, 2010). Further, it is argued by Sharpless and Barber (2009) that conflating CBT competence with client outcomes becomes something of a tautological argument, in which the measurement of competence and outcomes effectively become the same thing. Perhaps most importantly though, Rakovshik and McManus (2010) argue that, taken in isolation outcome measures do not actually measure either treatment effects or therapist competence in CBT, as client improvement could be due to the therapist using other models of psychotherapy, counselling or

supportive listening. Whilst not specifically CBT focused, Kaslow et al. (2007) drew together guidance on assessment of competence in professional psychology, under the auspices of the American Psychological Association's Task Force on Assessment of Competence in Professional Psychology (Kaslow et al., 2007). Following this Kaslow et al. (2009) identified 15 separate competencies that a professional psychologist should display, including ethics, professionalism, assessment, Socratic dialogue and competence in the delivery of interventions, any of which could contribute to a therapist's ability to provide CBT in an effective manner. Rakovshik and McManus (2010) in their review of evidence based training in CBT take a simpler approach however, defining competence as "the ability to appropriately apply CBT interventions that reflect the contemporaneous evidence base for the treatment of that patient's presenting problem" (p.498), and whilst broad this definition allows flexibility in being adaptable to the most recent evidence base in the field. As such this is the definition used in this thesis. Whilst the definition and measurement of competence are far from simple there is evidence of a strong, if at times small, link between assessed CBT competence and clinical outcomes (Barber et al., 2007, Brown et al., 2013), and further evidence of a relationship between training and therapist competence (Branson et al., 2105; Liness et al., 2019; Rakovshik & McManus, 2010; Simons et al., 2000; Westbrook et al., 2008), leading to the conclusion that both are relevant to the quality of CBT provided.

In practice however the development of competence in CBT must be seen in the context of the clinical settings in which those skills are utilised, the pre-existing level of competence of the participant and the level of competence needed to fulfil the required role (Shawe-Taylor, 2010). CBT training, to the level of accredited therapist with the BABCP requires placement in both university and clinical settings, and both novice training and CPD for experienced therapists frequently take place in a real world clinical environment. As such there is frequently a balance to be struck between the needs of the learner and their responsibilities to their clinical provider and clients, where the added value of the training must be weighed against the practical skill and competence that is gained, and the benefit that that competence brings to both client and service. Section 2 of this thesis explores the practical implications of on the job training in CBT, both from the perspective of the CBT novice,

undergoing a short, focused training programme and from the perspective of an experienced CBT therapist undertaking self-study whilst leading a service and carrying a clinical caseload. It focuses on both the support required to undertake such training and the implications for clinical services and clinicians when doing so.

Chapter 4

Chapter 4 (the service related study) of this thesis moves away from IAPT services to focus on another area of the author's clinical practice, that of supervision and training of first year core psychiatry trainees (CT1s), studying with the Royal College of Psychiatrists (RCPsych). As part of their training, core psychiatry trainees are required to undertake two psychotherapy cases with clinical patients. In the participating Trust one of these was in CBT and one in psychodynamic therapy. As the supervisor of the CBT programme, the author was responsible for the developing a short training course in core CBT skills, to enable the trainees to learn the skills required to undertake a clinical case under close supervision. This chapter evaluates the training and supervision programme developed by the author to facilitate this. In addition to investigating the perceived improvements in competence of the trainees, and pass rates based on the RCPsych assessment criteria, Chapter 4 also explores their experiences over the course of the programme, evaluates their perceptions of the usefulness of each component towards helping them meet their goals, and reflects on possible changes that they recommend.

Chapter 5

Chapter 5 constitutes a report of the author's professional practice. It continues to explore the practicalities of CBT training and development, but from the author's perspective of undertaking an evidence based CBT based CPD programme known as Self Practice and Self Reflection (SPSR) (Bennett-Levy et al., 2001; Bennett-Levy et al., 2015). The chapter uses a Reflective Topical Autobiographical (Johnstone, 1999) (RTA) design, with the author as the researcher/participant in an n=1 case study. Similarly to Chapter 4, Chapter 5 does investigate perceived changes in the author/participant's perception of their competence in CBT. However, given that SPSR has a

reasonable existing evidence base (Gale & Schroder, 2014 ; Laireiter & Willutzki, 2003), and in line with the motivation of this thesis, the main focus of the study is to explore the experiences gained undertaking the programme in a work environment, with a view to evaluating its possible practical application as a means of improving therapists' competence in the clinical team that the author leads.

This thesis brings together a range of clinical and research perspectives to investigate its core theme, that of making the best use of what we believe most improves the quality of therapy provision, in order to provide the best service in the most efficient manner to the public.

Section 1

Chapter 2

Early, Non Diagnostic, Psychological and Predictors of outcome in Individual Cognitive Behavioural Therapy for Common Anxiety and Unipolar Depressive Disorders: A Selective Review of Randomised and Non-Randomised Studies based on a systematic search.

Introduction

Anxiety and Depression

Anxiety and Depressive disorders are the most common health conditions in the world, with mean lifetime prevalence rates for Major Depressive Disorder (MDD) measured globally as between 14.6% and 19.8% (Bromet et al., 2011) and anxiety disorders between 9.2% and 28.7% (Sommers et al., 2006). The symptoms of depression can have a wide and severe impact on the lives of sufferers, affecting mood, the ability to enjoy experiences, sleep, and appetite amongst other things and is a demonstrable risk factor in harm seeking behaviour (American Psychiatric Association, 2003). Anxiety can have a similarly detrimental effect on lives, whether it is related to a specific aspect of someone's life (e.g., social phobia, panic disorder) or more globally as in Generalised Anxiety disorder (GAD) (American Psychiatric Association, 2003).

Cognitive Behaviour Therapy

Cognitive Behaviour Therapy (CBT) is a frequently used and evidence-based psychotherapy for a wide range of mental health problems, including common anxiety and depressive disorders and is one of the first line treatments for these conditions (National Collaborating Centre for Mental Health UK., 2010; National Collaborating Centre for Mental Health UK., 2011). It is efficacious via a broad range of treatment modalities such as individual, group, computerised, guided self-help across a wide range of disorders and demographic variables (National Collaborating Centre for Mental Health , 2010; National Collaborating Centre for Mental Health, 2011).

Terminology

Cognitive Therapy (CT) as described by Beck, Rush, Shaw & Emery (1979) differs considerably from the early Behavioural Therapy (BT) techniques described by Jones (1924) and Wolpe (1968) amongst others and has been described as the start of the "second wave" of behavioural treatments. However over the years CBT has grown to integrate many of the techniques of both therapies. Many of the studies reviewed in this paper describe cognitive and behavioural interventions separately. However some use the term Cognitive Therapy and Cognitive Behavioural Therapy interchangeably. The current review will utilise the term CBT to describe both CBT and CT and will describe specific behavioural techniques where they have been used separately. A number of studies focusing on third wave therapies (Hayes, 2004), such as Acceptance and Commitment Therapy (ACT) or Mindfulness Based Cognitive Therapy for Depression were identified. As these therapies may include very different practices to traditional (second wave) CBT they have not been included in this review.

Rationale for Current Review

Current health funding demands fast effective and consistent outcomes from psychotherapy, but the impact of client criteria, outside of symptom severity and diagnosis on the type of treatment that would be most effective has often been overlooked (e.g., National Collaborating Centre for Mental Health UK, 2011).

Whilst there have been reviews of non-diagnostic psychological predictors on therapeutic outcomes in the past, the majority of these have focused on either specific disorders (e.g. Knopp, Knowles, Bee, Lovell & Bower, 2013) or have been multi-therapy reviews (e.g. Greenberg et al., 2006). These latter are of limited use due to a growing body of evidence that psychological predictors of outcome such as motivation, expectation and personality factors may have different effects depending on the psychotherapy employed (Sotsky et a., 1991; Connolly-Gibbons et al., 2003). Many existing reviews also explore (but do not differentiate between) studies of group and individual psychotherapy. Whilst this allows for the greatest number of studies to be reviewed, there is evidence which suggests that predictors may vary in their interaction with these two treatment modalities (McEvoy et al., 2014).

Two pre-treatment psychological predictors of outcome, Dysfunctional Attitudes (DA) (Beck, 1964; Weissman & Beck, 1978) and Motivation (Miller & Rollnick, 2003; Ryan & Deci, 2008), have been well researched and are covered in other reviews.

The concept of DA relates to Beck's (1964) concepts of schema and the cognitive triad. Beck hypothesised that individuals who were predisposed to depression had developed distorted (or dysfunctional) beliefs at a deep level relating to the self, world and the future, which made cognitive distortions at more superficial "Negative Automatic Thought" level appear plausible and reasonable. Given that cognitive biases play a significant role in the cognitive theory of depression (Beck et al., 1979), it is unsurprising that DA have been found to have a significant relationship with CBT outcomes. In their review of pre-treatment patient predictors of outcome in CBT for depression Hamilton and Dobson (2002) identify strong evidence that high levels of DA are related to a poorer response to CBT.

Motivation, and related concepts such as self-directedness, autonomy, attitudes, ambivalence, readiness for change, and values have all been identified as key to the process of change (Miller & Rollnick, 2003; Ryan & Deci, 2008). Motivation was a factor included in Keijsers et al.'s (2000) non-systematic review of interpersonal factors affecting outcomes in CBT. They identified 27 papers investigating the relationship between motivation on outcomes or dropout. Twenty two of these found significant correlations, with high motivation predicting improved outcomes and reduced dropout (although not all of these were specifically related to common anxiety and depressive disorders).

Both of these reviews identify a clear relationship between specific patient psychological factors and symptom reduction in CBT. Identifying which other factors may be related to outcomes would make it easier to discern who would benefit most from an intervention and enable services to direct people towards an appropriate psychotherapy more effectively, improving their experience and enabling services to allocate resources in a more focused way. This knowledge could also inform funding streams to help ensure that services have appropriate resources to provide for the needs of

their patients. There are however no current reviews focusing on the predictive validity of psychological and attitudinal factors for individual CBT, across common mental health disorders.

Objectives

The wider objective of this thesis is to explore practical ways in which research can be utilised to improve CBT treatment. In line with this a decision was made to focus on pre-treatment predictors of outcome rather than "in treatment" predictors, in order that they, where identified, might be used to assist in the process of screening for treatment. Whilst identification of within treatment predictors and mediators of outcome (e.g. therapeutic relationship) are of interest, these are of less use in determining who might best be offered a given treatment at the point of entry to a service and are therefore not the focus of this review or thesis. For this reason, this review focused on only predictors and moderators of treatment outcome and not on mediators.

In summary this selective review aims to answer the question, what pre-treatment client psychological factors does existing research identify as being predictive of outcomes for individual CBT for common depressive and anxiety disorders?

This objective can be further specified using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Liberati, et.al, 2009) PICOS (population, intervention, comparisons, outcomes, and study design) framework as follows;

- Population: Adults without cognitive impairment and with the common anxiety and depressive disorders
- Intervention: individual, face to face CBT
- Comparisons: In effect the comparators in the review are pre-treatment psychological factors, as the review examined whether different outcomes are observed for different levels of these factors; in other words whether these factors predict different outcomes.

- Outcomes: the outcomes of interest are change in psychometric measures of anxiety and depressive symptoms from prior to (or in the initial stages of) treatment to post treatment or follow up.
- Study Design: The relevant aspects of the studies are primarily nonexperimental pre/post designs.

Method

Whilst it was not within the scope of this review to make use of full systematic review procedures, the review drew on aspects of the PRISMA (Liberati, et.al, 2009) guidelines where appropriate. This included a description of the rationale, use of PICOS based objectives (as discussed above), description of information sources and presentation of search strategy. There is no external pre-existing review protocol. No funding outside of financial support for the PhD programme was provided for this Review.

Eligibility Criteria

The following inclusion criteria were used for this review:

i) Studies must include an intervention condition that is CT or CBT.

ii) The intervention is conducted on a one-to-one basis between a therapist and a participant.

iii) The intervention includes face to face CBT between a therapist and a participant.

iv) The intervention must be aimed at addressing one of the following disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, (Edition relevant to the date of publication) (e.g., American Psychiatric Association, 2013).

   a. Major Depressive Disorder (MDD, Depression)
   b. Generalised anxiety Disorder (GAD)
   c. Social Phobia/Social Anxiety Disorder
   d. Obsessive Compulsive Disorder (OCD)
   e. Panic Disorder
   f. Agoraphobia

g. Health Anxiety (Illness Anxiety Disorder/Hypochondriasis)

h. Specific Phobia

v) All participants were aged 18 years or over

vi) Studies were published in the English language

vii) Studies included a pre/early and a post /late treatment symptom severity outcome measure and were designed to measure psychological predictors of changes in this.

viii) Studies included a measure of at least one psychological factor not directly related to the symptoms of a disorder itself (e.g., insight, thought action fusion), which was being investigated as a possible predictor of treatment outcomes.

ix) Psychological predictors were measured before the commencement of or within the first four sessions of psychotherapy.

x) Studies were published in an academically recognised peer reviewed journal.

xi) Participants were not selected on the basis of age (other than criterion (v)), gender, culture ethnicity or any other demographic variable.

xii) Participants were not selected on the basis of the presence of any comorbid physical or mental health condition or on the presence of cognitive impairment

xiii) Studies were conducted during or after 1979.

The cut-off date of 1979 was chosen as it was felt that studies conducted before the publication of Beck et al.'s (1979) seminal CT work *Cognitive Therapy of Depression* would be more difficult to incorporate into the CBT umbrella. The issue of comparability between interventions is of import when exploring predictors between diagnoses due to possibility of divergence due to presenting problem and style of therapeutic interaction. As such efforts were made to safeguard a degree of homogeneity in the studies reviewed. Studies of group, computer assisted and guided self-help based CBT were excluded because, whilst the theoretical model on which these forms of therapy are similar, the very different application could affect the relationship with the predictors investigated. Similarly the very specific onset of, and model of treatment for Post-Traumatic Stress Disorder led to the

concern that cross diagnosis comparability might be difficult. As a consequence studies of trauma focused CBT were also excluded.

Concerns about cross treatment comparability and a desire for this review to be applicable to the general population also led to the exclusion of studies specifically focusing on comorbidity, such as personality disorders and chronic pain. This was for two reasons. First it was felt that the treatment would be unlikely to focus specifically on the anxiety or depression without also having to take account of the comorbid disorder, thereby affecting the method of treatment. Secondly, it was felt that high levels of comorbid disorders could affect the relationship between predictors and outcomes. For the same reasons studies focusing specifically on participants with from specific demographic or cognitive factors such as age or cognitive impairment were also excluded as not being indicative of the general adult population. However, whilst many of the studies included identified demographic and comorbid factors within their participant groups, they did not exclude participants on this basis. These studies, including but not targeting participants with comorbid disorders, were included for two reasons. First there was no indication within the study protocols that such participants were treated differently to others, suggesting that core treatment for the presenting primary problem was utilised. Secondly, in neither targeting nor excluding participants based on demographic, socioeconomic or secondary clinical presentations, such studies were employing a sample that was arguably consistent with the population seen within IAPT services for the treatment of common anxiety and depressive disorders. Given the prevalence of comorbid presentations within society (Roca et al., 2009) it was felt that the omission of such studies would not be reflective of this population. A number of studies that relied heavily on Magnetic Resonance Imaging (MRI) and similar techniques were also excluded as they were predominantly neurological rather than psychological.

Finally, Health (or Illness) Anxiety is classified as a Somatic Symptom Disorder (American Psychiatric Association, 2013) or Somatoform Disorder (World Health Organization, 1992). It is included herein due to its similarities with anxiety disorder treatment in CBT.

Information sources

Existing review search

Searches were conducted from 1979, as discussed above, till June 2023. Due to the large body of pre-existing literature, a systematic search of current reviews that focused on CBT and included reviews of psychological predictors was conducted using the Psychinfo and Web of Science (which included MEDLINE) databases. Given that the reviews identified often covered a wide range of CBT predictors it was necessary to use wider search terms than those used for the primary study search. The following search terms were included (see Table 1).

Table 1

Search Terms and results for Pre-existing Reviews

Search terms	Limits	Database	Results
(CBT or (behav* thera*) or (Cognit* Behav* Thera*) or (Cognit* Thera*)) and (mediat* or Predict*or Moderator or suitab*)	Keyword (advanced) Peer Reviewed journal Cognitive Therapy Behaviour therapy and Behaviour modification Lit review systematic review Meta-analysis	Psycinfo	55
(CBT or "behav* thera*" or "Cognit* Behav* Thera*" or "Cognit* Thera*") AND (Predictors or Moderators OR suitab*))	Refined by: research domains: (Social Science) and research areas: (psychology) and document types: (review) and language: (English)	Web of Science (inc. medline,	360

Screening and eligibility were conducted by a single unblinded reviewer (the author) following the following procedure. Title searches were conducted via online databases and 31 reviews were selected for more detailed analysis. The resulting eight reviews were analysed using the Critical Appraisal Skills Programme (CASP) Systematic Review Checklist (Critical Appraisal Skills Programme 2018), following which four were included in this review. The other four were excluded because of quality issues which included a lack of a well-defined literature search and/or an ill-defined review question.

Primary Study Search

A systematic search was conducted first using the Psychinfo, Web of Science (which included MEDLINE) and CINHAL databases. The following search terms were included (see Table 2). As with the existing review search, primary study searches were conducted from 1979 till June 2023

Table 2
Search Terms and Results for Primary Studies

Search terms	Fields	Limits	Database	Number of Results
((((CBT or "behav* thera*" or "Cognit* Behav* Thera*" or "Cognit* Thera*") AND (Predictors or Moderators OR suitab*) and (depression or anxiety or "post traumatic" or Panic or *phobia or GAD or hypochondria*) not (Anorexia or bulimia "eating disorder*" or alcohol or youth or child* or computer* or internet or psychosis or schiz* or "personality disorder*" or binge or "weight loss" or bipolar or adolescent or young or "substance miss" or opioid or cancer or anger or epilep* or pain or "substance use"))))	Basic Search, Topic	Refined by: RESEARCH AREAS: (PSYCHOLOGY) AND DOCUMENT TYPES: (ARTICLE OR CLINICAL TRIAL OR ABSTRACT) AND RESEARCH DOMAINS: (SOCIAL SCIENCES) ANDLANGUAGES: (ENGLISH) Timespan: All years. Search language=Auto	WEB of Science	1466
(CBT or (behav* thera*) or (Cognit* Behav* Thera*) or (Cognit* Thera*)) and (mediat* or Predict*or Moderator or suitab*)	Keyword Terms mapped to subject heading	Cognitive therapy and behaviour therapy and behaviour modification Adulthood Peer reviewed journal English	Psychinfo	726
((((CBT or "behav* thera*" or "Cognit* Behav* Thera*" or "Cognit* Thera*") AND (Predictors or Moderators OR suitab*) and (depression or anxiety or "post traumatic" or Panic or *phobia or GAD or hypochondria*) not (Anorexia or bulimia "eating disorder*" or alcohol or youth or child* or computer* or internet or psychosis or schiz* or "personality disorder*" or	All	English language, peer reviewed, research article, publication type: journal article, all adult special interest psychiatry/psychology	CINAHL	19

binge or "weight loss" or bipolar or adolescent or young or "substance miss" or opioid or cancer or anger or epilep* or pain or "substance use"))))

Screening and eligibility were conducted by a single unblinded reviewer (the author) conforming to the following procedure.

Screening. Initial search results were screened for with reference to the study criteria.

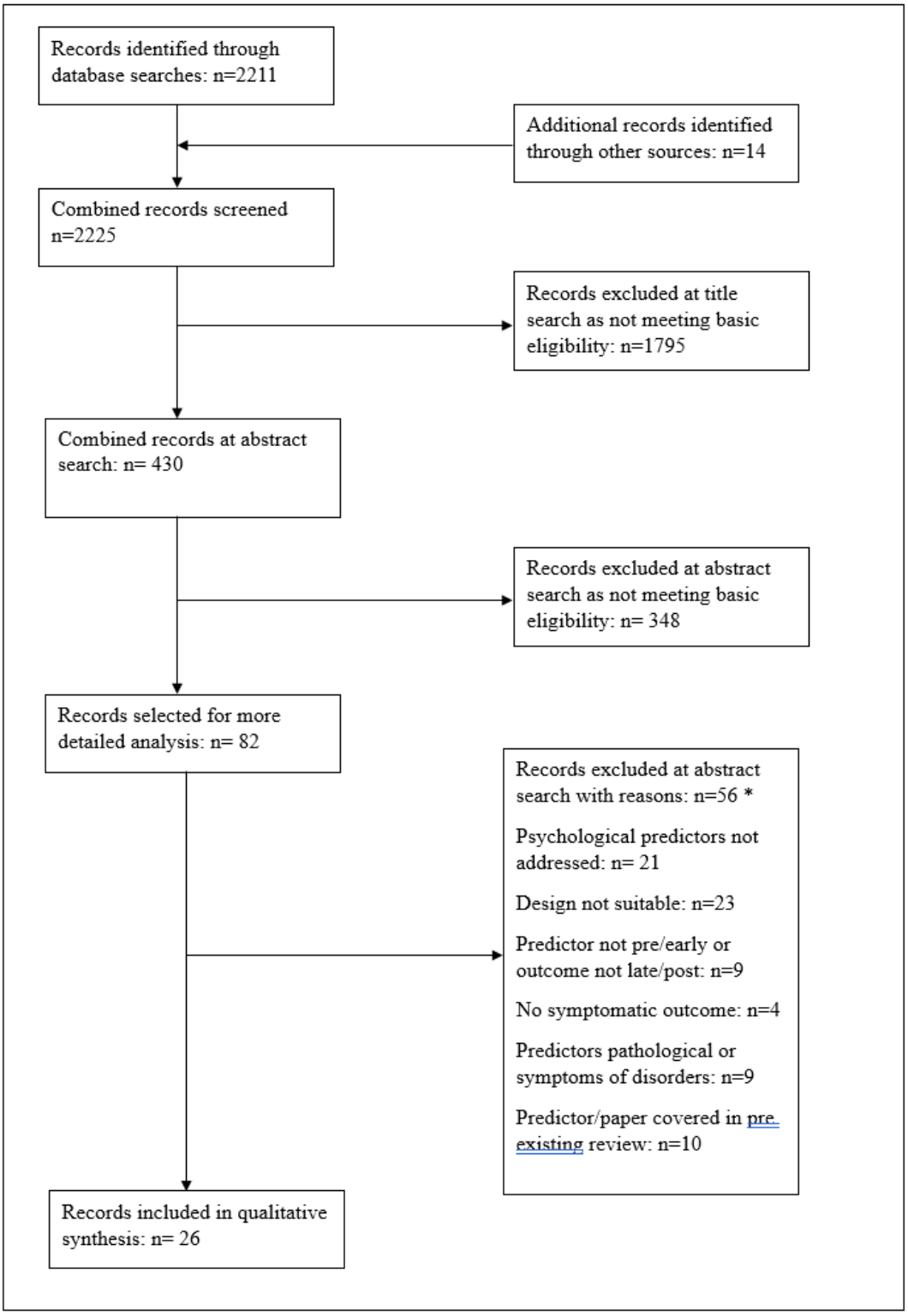
Detailed Analysis. The resulting 30 studies were analysed using the "Standard quality assessment criteria for evaluating primary research papers from a variety of fields" (Kmet et al., 2004). Whilst this has not been empirically validated it is a widely used quality assessment tool in published studies. Data and results relating to the aims of this review were extracted and reviewed. Data included in studies but not directly related to this review were not.

Studies identified through other documents. Fourteen studies were identified through analysis of the existing literature that were not identified by the initial database search. This number is slightly higher than typical in this type of review despite the extensive literature search. The author hypothesises that there are two possible reasons for this. First, investigations of predictors of change are often conducted through secondary data analysis within another study, such as a treatment comparison study. As such they are not always identified in either title or keyword searches. The second reason is that only positive relationships tended to be described in study abstracts. As evidence is sporadic for many of the predictors described in this review, those investigated were not always mentioned in the abstracts of primary studies when no relationship was found.

Study selection flow chart. A PRISMA flow chart detailing the selection procedure for the review is incorporated for ease of use (see Figure 1).

Figure 1

PRISMA flow chart



* Some studies met more than one exclusion criterion

Results

Categorisation of Predictors

The potential predictors of the efficacy of CBT for anxiety and depression were divided into the following categories based on similarity and differences. Recall from the introduction that Dysfunctional Attitudes and Motivation have been adequately reviewed and will not be covered further in this review.

- Dysfunctional Attitudes
- Motivation
- Expectancy/Credibility
- Treatment preference
- Beliefs about illness
- Interpersonal styles/problems
- Personality
- Multi-factor tools

The first six of these were based on the names used in the research included in that section (Expectancy and Credibility were amalgamated due to reasons described below). Personality is a composite of different factors, either specifically related to a defined theory of personality (e.g. Costa and McCrae, 1989) or to participant's emotional reactivity and processing. The category "multi factor tools" referred to predictors that combined multiple factors, within a single measure. Only one such measure was identified as within the scope of this review: the Suitability for Short Term Cognitive Therapy Scale (SSCT) (Safran et al., 1993). Each of these categories will be further defined in the relevant section of the review. The author is aware that alternative groupings are possible. Studies that investigated more than one predictor are commented on in each applicable section. They are critically analysed on the first occasion they are referenced unless there is a much stronger relevance to a later section.

Pre-existing Reviews

There were a number of pre-existing reviews into predictors of outcome in CBT. These tended to focus on broad predictors for CBT for specific disorders (e.g. Knopp et al., 2013) rather than psychological factors across a range of disorders. As has been detailed above, the reviews were selected on the basis that their findings were relevant to the current review question and evaluation using the relevant CASP checklist suggested that they were of adequate quality (see search strategy).

A number of multi-psychotherapy reviews (e.g. Bohart & Wade, 2013) were also identified but these were explored for access to CBT specific papers rather than reviewed in their entirety as their conclusions did not relate primarily to CBT.

The quality and scope of pre-existing reviews varies significantly, but it is surprising how few systematic reviews have been conducted in this area. Only three of the predictors identified were covered comprehensively, those of willingness to participate/compliance (as measured by homework completion), motivation and dysfunctional attitudes (DA). Further, perhaps due to their age, not all of the identified reviews provide a full methodology with a clear presentation of search strategy and inclusion/exclusion criteria.

Whilst it has not been possible to screen all previously reviewed studies for concordance with the current review's inclusion criteria, efforts have been made to ensure that reviews are relevant. Where identified, reviews were excluded if the only papers investigating psychological predictors were outside of the scope of this review (i.e., those based on group CBT (Eskilsden et al., 2009)).

Study Designs

A variety of methods of design and analysis can be employed in the search for predictors and moderators of treatment outcome and for the sake of clarity and space it would be beneficial to explore these together rather than when reviewing individual studies. In the first (and simplest) of these methods, psychometric symptom severity measures are administered to participants prior to the trial beginning and after treatment has been completed. In some cases measures are also administered

at follow up, commonly some months later. Predictor measures are also administered before or early in the treatment stage of the trial and regression analysis is conducted to determine whether there is a relationship between the value of the predictor measure and that of the outcome variables. An alternative method is to explore the relationship between the predictor variable and changes in the severity outcome measure. That is the difference between the pre and post treatment measures of outcome rather than the raw, post treatment, data. In doing this the investigator is able to explore the relationship between the potential predictor and degree of change in symptom severity. These methods are the simplest to conduct and are, by far the most commonly employed in the studies reviewed in this paper. Both of them suffer from a number of drawbacks however. First, as already discussed, many of the studies identified herein investigate predictor analysis as part of a wider treatment comparison study, often an RCT. In these studies, outcome measures for one or more treatment (usually psychotherapy or pharmacotherapy) are compared with those of a control group (often waiting list or "treatment as usual"). This presents a particular issue when more than one treatment is being investigated. Whilst it is possible to conduct the predictor analysis independently for each individual treatment group this often exacerbates issues of power, as the sample size for each analysis is only as large as that of the individual treatment group (often more than halving the overall sample size of the study). A method that is commonly used to attempt to overcome this difficulty is to investigate predictor variables for all groups as a whole and subsequently look for an interaction effect between the data for individual groups. For example, if a study includes two treatments T1 and T2 one could either investigate predictor correlations for T1 and T2 separately or combine T1 and T2 into a single group T and conduct regression analysis on the larger sample. Once this is done the regression data for T can be split up into T1 and T2 again and an exploration of possible relationships between these data can be conducted. If no interaction is found, then it is typically assumed that the predictor relationship applies to both treatments equally. However, this method is still limited by the need for sufficient power to conduct the between group interaction analysis. A second difficulty with these methods is that they essentially look for a linear relationship between predictor and outcome variables. Whilst this is generally sufficient, it can become problematic when investigating more complex interactions. This can be overcome using a number of statistical techniques however, such as

the Regression Trunk Approach (RTA) model employed by Dusseldorp et al. (2007) to identify a curvilinear relationship between locus of control and symptom change during CBT for Panic Disorder.

Perhaps the most important difficulty with these methods of analysis, however, is that without a control group one cannot be sure that any relationship identified between predictors and outcomes is actually related to the treatment employed. For example, it might be that the predictor is simply associated with changes in symptoms that naturally occur over time, regardless of whether or not someone has received treatment. A third, simple Randomised Control Trial (RCT) design can be used to overcome this difficulty. RCTs are trials in which participants are randomly (or pseudo randomly) assigned to a specific intervention or control group prior to the active component of the trial beginning.

Other than the intervention delivered, participants are treated identically regardless of group in an attempt to rule out extraneous or "confounding" factors that may influence the outcome of the trial. Ideally participants and researchers should be "blind" to who is assigned to which group and whilst this can rarely be fully achieved in psychotherapy trials, all attempts should be made to do so where possible (Sibbald & Roland, 1998). Using this method participants are stratified on the basis of the predictor variable during randomisation to treatment or control groups. That is, if one were investigating perceived treatment credibility as a predictor of outcomes (as many of the studies reviewed seek to do), participants would first be stratified into sub-samples based on levels of credibility (e.g., high credibility and low credibility groups), then half of each stratum would be randomly allocated to the treatment group and half to the control group. It is then possible to examine whether the effect of the intervention, as measured by the post-treatment difference between the treatment and control groups on the outcome measure, significantly differs for different levels (or strata) of the predictor; in other words, whether the predictor moderates the effect of the treatment. The advantage of this approach is that we can be more confident that any observed treatment effects are due to at least some aspect of the treatment.

However, even this design does not allow for the identification of a causal relationship between the predictor and treatment effect, as levels of the predictor variable have merely been randomised and not manipulated by the researcher. As such, we cannot be sure that any identified predictor–treatment effect relationship is caused by the predictor, since it could be due to other confounding factor(s) that are associated with the predictor. For example, hypothetically it might be that it is initial symptom severity, as opposed to treatment credibility, that has a causal effect on treatment outcome. If people with lower symptom severity were more likely to find a treatment credible, then we could still find credibility to be a significant predictor of outcomes even though it was not a cause. Therefore, the best we can conclude from such designs is that the findings are consistent with the possibility of a causal relationship between the predictor and treatment effects.

In principle, in order to overcome this issue, changes in the level of the predictor would need to be brought under experimental control, and a factorial experimental design used, with group (treatment vs. control) as one factor and level of predictor as the other, and participants randomly allocated to each of the cells of the design. In our credibility example an investigator might randomise, or pseudo randomise their sample into high and low credibility conditions and then consciously seek to make the treatment appear more credible to the former than the latter. Participants within each of these high and low credibility conditions would then be randomly allocated to either a treatment or control group. If credibility were found to moderate treatment effects in such a design, we would have more compelling evidence that changes in credibility were the cause of the differences in treatment effects. However ethically and practicality such a design is difficult to implement; for example, it is not possible to experimentally manipulate some predictors (e.g. gender), and it may be ethically inappropriate to manipulate others (e.g. giving a misleading sense of a treatment's credibility). Unsurprisingly, therefore, none of the studies reviewed in the current paper adopt the RCT approach to predictor analysis.

Study Methodological and Design Issues

A number of common methodological issues were identified in the studies reviewed. As such it is helpful to explore them in advance. The most prevalent of these was one of sample size and low power. This has two possible effects. First a very small sample size can lead to the possibility of surprising and potentially erratic results (e.g. Price & Anderson, 2012). Secondly a consequence of sample size is a reduction in the statistical power of the study. The search for moderators tends to be one of correlation, leading to the need for larger sample sizes, particularly when including large numbers of predictors in the model. Looking for small effect sizes between 5 predictors for example would require a sample size of around 667 (Field, 2013) to be reasonably sure of avoiding a Type 2 error (failing to detect an existing relationship). This leads to two difficulties in reporting. First the ability to identify small and medium effect sizes is severely limited. Secondly, in order to maintain power, some studies have amalgamated a number of predictor variables into one, either taking an average or a sum of a number of potentially very different factors (e.g., Freeston et al., 1997). The decision to amalgamate data in this way is often understandable due to the low power of many studies but can affect how meaningful the composite outcome score is. It may also leave the authors open to questions about whether a decision to do so was made a priori or post hoc. If this was done a priori these studies could have benefitted from greater explanation of their reasoning, if post hoc then any deductions can at best be regarded as exploratory and would benefit from repetition.

There is also the temptation when working with a high number of predictors to either report on multiple correlates, highlighting the small number of significant results (e.g., Borkovec & Mathews, 1988) or post hoc scan the results for a significant result and then retro fit a study design. This is a particular problem as it increases the chances of finding an apparent relationship where one does not exist. For example, a significance level of 0.05 indicates that there is a 1 in 20 chance of an apparently significant result being due to chance. If a reader were to read 20 sets of results, then on average he would find one that met the significance criteria even if the null hypothesis were true. Whilst this last issue can rarely be proven there are studies identified within this review in which the authors could provide stronger theoretical rationales for their decision to include one set of predictor

analyses and discard another (e.g. Renaud, Russell, & Myhr, 2013). More idiosyncratic methodological and design issues are considered as they arise for individual papers.

Studies Reviewed

Studies reviewed, predictor and outcome variables measured, and predictor categorisation are presented in Table 3 below.

Table 3a

Studies reviewed, predictor and outcome variables measured and predictor categorisation

Citation	Sample Size	Study Design	Interventions	Predictor Variables	Outcome Variables	Predictor Group
Bagby et al. (2008)	280	Pre/post	CBT/AD	personality traits	Depression symptom reduction	Personality
Bakker et al. (2000)	66		CBT	Treatment preference	Panic symptom reduction	Treatment preference
Borkovec and Costello (1993)	55	Pre/post	CBT, applied relaxation	Expectancy, credibility	GAD symptom reduction	Expectancy/credibility
Borkovec and Mathews (1988)	30	Pre/Post	CBT, desensitization training	Expectancy, credibility	GAD symptom reduction	Expectancy/credibility
Borkovec et al. (2002)	69	Pre/Post	CBT	Expectancy, credibility, Interpersonal problems	GAD symptom reduction	Expectancy/credibility interpersonal styles
Cohen et al, (2008)	62	Pre/Post	CBT	relationship between daily stressors and negative affectivity, coping styles and negative automatic thoughts	Depression symptom reduction	Personality
Dunlop et al. (2012)	77	Pre/Post	CBT/AD	Treatment preference	Depression symptom reduction	Treatment Preference
Dusseldorp et al. (2007)	129	Pre/Post	CBT/AD	Locus of control	Panic symptom reduction	Beliefs about illness
Gunthert et al. (2005)	43	Pre/Post	CBT	relationship between daily stressors and negative affectivity, coping styles and negative automatic thoughts	Anxiety/Depression symptom reduction	Personality

Table 3b

Studies reviewed, predictor and outcome variables measured and predictor categorisation

Citation	Sample Size	Study Design	Interventions	Predictor Variables	Outcome Variables	Predictor Group
Hardy et al. (1995)	117	Pre/Post	CBT/PT	Credibility	Depression symptom reduction	Expectancy/Credibility
Hardy et al. (2001)	24	Pre/Post	CBT	Interpersonal attachment style	Depression symptom reduction	Interpersonal styles/problems
Hardy et al (1998)	117	Pre/Post	CBT/Psychodynamic-Interpersonal Therapy	Interpersonal attachment style	Depression symptom reduction	Interpersonal styles/problems
Leykin et al. (2007)	174	Pre/Post	CT, AD or pill placebo	Expectancy, treatment preference	Depression symptom reduction	Expectancy, treatment preference
McEvoy et al. (2014)	199	Pre/Post	CBT/Group CBT	Interpersonal problems	Depression symptom reduction	Interpersonal styles/problems
Myhr et al (2007)	113	Pre/Post	CBT	optimism/pessimism about treatment, “hopefulness about CBT”, Suitability for short term cognitive therapy scale	Anxiety/Depression symptom reduction	Expectancy/credibility, multifactor tools
Mortberg and Andersson. (2014)	54	Pre/Post	CBT/Group CBT	“Self-directedness”	Social Phobia symptom reduction	Personality
Price and Anderson’s (2012)	12	Pre/Post	CBT (with Virtual Reality exposure), Group CBT	Expectancy		Expectancy/credibility

Table 3c

Studies reviewed, predictor and outcome variables measured and predictor categorisation

Citation	Sample Size	Study Design	Interventions	Predictor Variables	Outcome Variables	Predictor Group
Renaud et al. (2013)	113	Pre/Post	CBT	optimism/pessimism about treatment, "hopefulness about CBT", "security measures"/avoidance		Expectancy/credibility
Renaud et al. (2014)	256	Pre/Post	CBT	Suitability for short term cognitive therapy scale	Anxiety/Depression symptom reduction	multifactor tools
Renner et al. (2012)	523	Pre/Post	CBT	Interpersonal problems: agency, communion and distress	Depression symptom reduction	Interpersonal styles/problems
Saatsi et al. (2007)	97	Pre/Post	CBT	Interpersonal attachment style	Depression symptom reduction	Interpersonal styles/problems
Safran et al. (1993)	66	Pre/Post	CBT	Suitability for short term cognitive therapy scale	Anxiety/Depression symptom reduction	multifactor tools
Steketee et al. (2011)	39	Pre/Post	CBT	Expectancy/credibility	OCD symptom reduction	Expectancy/credibility
Strauss, et al. (2018)	111	Pre/Post	CBT	Expectancy/credibility	OCD symptom reduction	Expectancy/credibility
Vittengl, et al. (2019)	152	Pre/Post	CBT	Expectancy Credibility Beliefs		Expectancy Credibility Beliefs

Outcome expectancies/treatment credibility

Treatment credibility and outcome expectancy have been defined in a number of frequently overlapping ways, to a degree that to separate them could be regarded as artificial. Bohart and Wade (2013) include beliefs "about the efficacy of therapy" (p.234) within their description of psychotherapy expectations and many studies amalgamate the two factors to the extent of using the same measure for both or use the terms interchangeably (e.g., Freeston et al., 1997; Morisson & Shapiro, 1987; Steketee et al., 2011). This is not always identified in existing reviews. Keeley et al. (2007), for example, make the assumption that Freeston et al. (1997) found "no significant relations between expectancy and treatment outcome" (p. 124) when the authors had been measuring a mean of ratings of expected results, treatment logic, interest and therapist factors. Freeston et al.'s (1997) decision not to publish raw data for each of these factors is disappointing from the perspective of this study but, to a degree, justified by the internal consistency of 0.86 between the ratings, reinforcing the concept of an artificial and impractical distinction between them.

It can be argued, however, that expectations and credibility are very different, if closely correlated constructs (Devilly & Borkovec, 2000; Kazdin, 1979; Ilardi & Craighead, 1994). Kazdin (1979) defines credibility as relating to the believability and logicality of the treatment and expectancy for success as an individual's belief in the possibility of improvements. There may also be different processes underlying these constructs. Devilly & Borkovec (2000) suggest that expectation is related to an affective experience of what a patient believes can be achieved whilst credibility is related to an individual's rational understanding of and beliefs about theoretical basis of the model. Not all researchers utilise the same definitions however and this lack of clarity in reporting makes it difficult to address them individually at times. Consequently, this review will attempt to separate them where possible and identify the unified theme as "expectancy/credibility" where it is not.

In addition to their possible relationship to patient experience and outcomes, treatment expectations and credibility may also affect research into psychotherapeutic efficacy. As Kazdin (1979) notes, many RCTs compare psychotherapy against a pseudo-treatment control group, in order

to factor out a number of nonspecific psychotherapy factors. Given that these pseudo-treatments may not have the empirical validity of the modality being investigated it is possible that they may differ in the credibility they present to the client, and consequently in the expectancy they generate. This possible discrepancy could also be related to researcher allegiance effects in psychotherapy trials (Luborsky et al., 1975; Leykin & DeRubeis, 2009) as therapists with a strong allegiance to a particular psychotherapy may explain with greater enthusiasm and credibility than alternative treatments.

A great deal of research has been done in this area in the field of integrative psychotherapy, and patient expectations/credibility have been identified as amongst the core principles of change in this process (Goldfried, 1980; Weinberger & Eig, 1999). The facilitation of positive client expectations is regarded as a key factor in more than one form of psychotherapy (Greenberg et al., 2006) and expectations have been shown to be related to positive outcomes across wider psychotherapy (Constantino et al., 2011). As such it might be expected that evidence for a positive relationship between client expectation/credibility and outcomes would be robust in the CBT literature. CBT specific research in this area, however, reveals mixed results.

Prior Reviews.

In their 2008 review of "Clinical predictors of response to cognitive-behavioral therapy for obsessive–compulsive disorder" Keeley et al. (2008) identified 3 papers (Freeston et al., 1997; Lax et al., 1992; Vogel et al., 2006), none of which identified a significant relationship between positive expectancies and outcomes. Keeley et al. (2008) argue that this was counterintuitive and might be related to a restricted range of expectancies in the studies they reviewed, although they only cite data from Freeston et al. (1997) when making this argument. This review is reasonably robust but has limited breadth in its search criteria.

A more recent review by Knopp et al. (2013) identified seven studies exploring treatment expectancy/credibility as a predictor in CBT for OCD, including two of the three papers that Keely et al. (2008) drew upon. Knopp et al. acknowledged that it would have been beneficial to conduct a meta-analysis of these results, however due to lack of comprehensive reporting in some of the papers

they reviewed this was not possible. Instead, they utilised a box score analysis in which they tabulated results and categorised them as positive, negative or non-significant in terms of relationship with outcomes. This revealed inconsistent results with no good evidence for an overall relationship between expectancy and outcomes.

The only review identifying a consistent significant relationship with expectancies or credibility was into depression. Ilardi and Craighead (1994) cite two studies (Fennell & Teasdale, 1987; Morrison & Shapiro, 1987) that identified significant correlations between treatment credibility and outcomes. They also cite studies by Nau et al. (1974) and Kazdin and Kraus (1983) which identify a strong relationship between the credibility of treatment rationales and patient expectancy.

This apparent contradiction in the current review literature may be associated with a number of factors. The first of these might be the disorders studied. The two reviews finding no significant relationship were both of OCD whilst the one review finding a positive relationship was of depression. Date of publication might also be a factor, with Ilardi and Craighead's (1994) review being published significantly prior to either of the two OCD reviews. Finally, the measures used in each studies might be different, although it is known that at least one study reviewed in the OCD literature, that did not identify any significant relationship with outcomes (Freeston et al., 1997), used a measure of credibility developed for Morrison and Shapiro's (1987) study, which identified a significant relationship. The search for an explanation at this stage is perhaps premature however, as the mixed results identified by pre-existing reviews are a reflection of the results obtained by the additional studies reviewed herein. A further 11 studies were identified, with five identifying some form of significant relationship between expectancy/credibility and psychotherapy outcomes, five finding no statistically significant relationship and one identifying an indirect relationship with outcomes.

Studies

Owing to the large number of studies reviewed in this section, studies of expectancy and credibility have been sub divided into those that identify a direct significant correlation with outcomes, those that identify an indirect correlation with outcomes, and those that do not.

Studies identifying a direct significant correlation. Of the five studies identifying a significant predictor effect for expectancy and/or credibility, four drew on data from treatment comparison studies and one from a dismantling study of CBT. None utilised a control group in their exploration of predictors.

The first of these studies (Borkovec & Mathews, 1988) compared CBT with nondirective and coping desensitization therapy for GAD. Borkovec and Mathews (1988) utilised three items (logic of the treatment, expected success and willingness to recommend the treatment to a friend) from the four item Treatment Credibility Questionnaire (TCQ) (Borkovec & Nau, 1972; Morrison and Shapiro, 1987), alongside a single item 1-100% Expectancy of Improvement scale. A version of the TCQ is utilised by a number of the studies of expectancy/credibility in this review. Whilst it has not been validated, different versions of it have been shown to have good internal consistency (Freestone et al., 1997; Morrison & Shapiro, 1987; Rodebaugh, 2004; Taylor & Alden, 2010). There are, however, a number of issues with the varied use of this questionnaire that will be discussed in the summary and synthesis section. Borkovec and Matthews (1988) identified significant correlations for 14 of 33 possible comparisons (11 outcome measures taken at three time factors (treatment end, 6 month and 12 month follow up) for expectation. Following Bonferroni adjustment this reduced to 3/33 at 6 month follow up only. They found only 4/33 significant correlations for credibility, which reduced to 1/33 following Bonferroni adjustment. All of the correlations for expectancy or credibility were positive, with increased predictor scores relating to better outcomes. These sporadic results are difficult to explain in terms of the therapies themselves, but as the study had only 30 participants it is possible that other correlations were missed due to Type 2 errors. With this in mind Borkovec and

Matthew's decision to include so many correlates for such a small sample size may have made it difficult to draw any clear conclusions from this paper.

Another study with extremely low sample size (n=12), Price and Anderson's (2012) study of group versus individual CBT (with virtual reality exposure) for public speaking fears within social anxiety disorder, found that higher pre-treatment outcome expectancy was related to greater rate of reduction in public speaking fear in both treatment groups. The authors administered two self-report measures of public speaking fear (the Public Speaking Fear Reduction in Social Phobia Report of Communication Apprehension-Short Form (McCroskey, 1978) and the Self Statements during Public Speaking (Hofmann & DiBartolo, 2000)) prior to treatment, at session four, and post treatment. The TCQ was administered following the first therapy session (in which they explained the treatment rationale). They found patient expectancy/credibility had a medium to large statistical effect on outcomes, accounting for 33% of variance across both treatments with no significant difference in the expectancy/outcome relationship between the two treatment groups. This finding seems high however, particularly given the mixed results of other trials. This may be a consequence of the variant form of CBT, but given that the treatments primarily followed the CBT model it seems most likely that is something of an outlier perhaps as a consequence of a very low sample size.

Borkovec and Costello's (1993) study was a comparison between CBT and applied relaxation in the treatment of 55 adults with GAD. The authors utilised the same measures as Borkovec and Mathews (1988) to measure expectancy and credibility in the first session. Borkovec and Costello identified a significant positive relationship between expectancy and 13 out of 30 possible measurements of outcome (ten outcome measures over three time points: treatment end, 6 month and 12 month follow up). These included significant relationships with both the Penn State Worry Questionnaire (Meyer, Miller, Metzger & Borkovec, 1990) and the Zung Self Rating of Anxiety Scale (Zung, 1971) at all three time points. There were no significant correlations between credibility and outcomes. The authors did not publish predictor data independently for treatments but identified that there were no significant interactions between treatments. As with Borkovec and Mathews (1988) the authors chose to investigate a large number of possible correlates, making it more difficult to draw

conclusions from their results. The correlates identified in this study are easier to relate to theory than in Borkovec and Mathew's (1988) study however, as there is a greater consistency in the relationships that were found, with significant correlations for at least two major validated anxiety scales over all time frames. This, along with a much larger sample size gives more weight to these findings.

Hardy et al. (1995) used the Opinions about Psychological Problems Questionnaire (OPP) (Pistrang & Barker, 1972) and the TCQ, to explore the relationships between credibility and outcomes for 117 depressed adults randomly assigned to 8 or 16 sessions of either CBT or PT. The OPP was administered pre allocation and Hardy et al. identified no significant relationship between credibility of CBT and CBT outcomes with this measure. However, they also used Morrison and Shapiro's (1987) version of the TCQ before and after the first session of psychotherapy. Hardy et al. (1995) did not compare outcomes between treatment groups using the TCQ but found a significant positive correlation between both ratings and outcomes for 8 session psychotherapy but not 16 sessions for the combined treatment data. The apparent inconsistency in findings between the OPP and TCQ is not necessarily due solely to the inclusion of the PT data. The authors also found no correlation between the OPP and TCQ scores for the CBT treatment group, highlighting the potential difficulties of comparing multiple measures of the same construct. It would however have been interesting to see TCQ data for individual treatment groups.

The final study that identified a positive correlation with outcomes was a component analysis of CBT for Generalised Anxiety Disorder (GAD) conducted by Borkovec et al. (2002). Borkovec et al. allocated 69 adults with GAD to one of three treatment groups; cognitive component only CBT (CT), self-control desensitization and relaxation (SCD) and full CBT. As with Borkovec's other studies, the authors used Borkovec and Mathews (1988) procedures for measuring credibility and expectancy, identifying a significant correlation between credibility and outcomes, at end of treatment and at 12 month follow-up, although only the end of treatment correlation remained significant after Sime's (1986) conservative version of the Bonferroni adjustment. They found no relationship between expectancy and outcomes however. As with other studies in this section, this study did not separate its results by treatment group. However, as all treatments had a CBT focus in this study, this has less of

an impact on the current review. Like Borkovec's other studies however, it does benefit from separating credibility and expectancy in its results.

Studies identifying no significant correlations. In addition to the eight studies identified in pre-existing reviews, discussed above, five further studies were identified that found no significant predictor effect for expectancy or expectancy/credibility combinations.

The first of these studies (Strauss et al., 2018) investigated predictors of outcome for two forms of CBT treatment for OCD, namely Exposure and Response Prevention (ERP), using a method described by Foa and Kozac (2004), and Stress Management Training (SMT; Simpson et al., 2008). Of relevance to this review, Strauss et al. investigated the relationship between patient treatment expectancy (in session two of fifteen) and therapy outcomes for the two treatment types. Strauss et al. found no significant association between participant early treatment expectancies and treatment outcomes collapsed across the two CBT treatments. However, a key limitation of this study is that it does not separate expectancy predictor results by CBT treatment, only providing results for an overall prediction analysis. Therefore, it remains possible that expectancy could have been a predictor for one of these CBT treatments but that was masked by it not being a predictor in the other

A further study exploring the relationship between CBT treatment expectations and outcomes yielded mixed results. Vittengl et al. (2019) analysed data from a wider study of the efficacy of continuation phase CBT in reducing recurrent depression (Jarret & Thase, 2010). In this study, 152 participants diagnosed with recurrent Major Depressive Disorder were offered 12-20 sessions of acute phase CBT for depression, with a subset (n=51) offered longer term (10 sessions) of further "continuation phase" CBT. Vittengl et al.'s analysis investigated whether participants' expectations of either the outcome of therapy, or the time expected to achieve recovery, were predictive of outcomes at either the acute or continuation phase of therapy. Perhaps surprisingly, whilst expectations of the effectiveness of therapy did not predict outcomes, beliefs about how long it would take to achieve recovery did, with those participants who predicted that a shorter course of therapy would be

necessary achieving improved symptom outcomes at the end of both acute and continuation phase therapy.

A third study (Steketee et al., 2011) investigated predictors of pre/post symptom improvement in individual CBT for 39 participants with OCD. The authors' found no significant correlation between symptom change after CBT and expectancy/credibility as measured by four questions based on the TCQ. Steketee et al.'s study included a large proportion of participants with comorbid axis one disorders (n=19), which allowed for a high degree of ecological validity but as the authors did not analyse the data separately it is not known whether the results would have been the same for a pure OCD group.

The fourth study, by Leykin et al. (2007), drew on data from a large multisite trial (Derubis et al., 2005) to investigate whether receipt of a preferred treatment (CT, antidepressant medication (AD) or pill placebo) predicted outcomes for adults with moderate to severe MDD. Participants were asked to rate both their preferred treatment and that which they expected to be most effective before being randomly allocated to a treatment group. Leykin et al. (2007) found no significant interactions between the preference or expectation and treatment outcomes or dropout, but preference and expectations were, unsurprisingly, highly correlated. This study benefits from a large sample size (n=174) and has the advantage that it draws data from a robust RCT. Unfortunately, despite analysing data from the randomised treatment groups the authors chose not to compare this with control group (placebo). Obviously, this might be difficult given that few patients are likely to have expressed a preference for placebo but given that the participants were blind to whether they received AD or Placebo it may have been possible to explore the data from the placebo group in light of a preference for CBT or AD (which they believed they were receiving). The authors accurately identified a number of other limitations; first a randomisation failure was indicated by significant variations between the preference scores in the two treatment (CBT, AD) groups. Whilst this may have been avoided had Leykin et al.'s been the primary study for which participants were randomised, it has little impact on this review (which is only interested in the CBT arm of the study). Secondly Leykin at al. identify that only the direction and not the degree of preference was measured, making the

measures less sensitive and reducing the likelihood of finding an effect if one existed. This was compounded by the fact that potential participants with high levels of preference were likely to be excluded due to a desire not to be randomised to treatment. Finally, Leykin et al. (2007) accept that, like many of the studies presented in this review, the power in their study was not high enough to identify small effect sizes.

The final study reviewed, identified no relationship between expectancy/credibility and outcomes in CBT (Myhr et al., 2007. It differs from the other studies in this section, in that it was a dismantling study of the Suitability for Short Term Cognitive Therapy Scale (SSCT; Safran et al., 1993), a 10 factor semi structured interview designed to predict outcomes in CBT. Myhr et al. (2007) did not specifically investigate the terms expectation or credibility but failed to show any direct correlation between clinician rated, client optimism/pessimism about treatment or client rated "hopefulness about CBT" and outcomes for a treatment group of adults with a range of anxiety and depressive disorders. This study, has a good sample size (n=113) but engages in multiple correlations. Whilst all the correlations are relevant to the theoretical model of the study it does leave open an increased possibility of both type one and type two error, as discussed in the study design section. With regard to the type two error this would have been particularly relevant to the detection of smaller effect sizes. However, the fact that neither therapist nor client rated measures of positivity or hopefulness showed any significant correlation with outcomes does not give weight to the idea that positive expectations have a simple relationship with outcomes. This study is discussed in greater detail in the section on multi factor trials below.

Studies showing an indirect relationship. It is possible that the relationship between expectations/credibility and outcomes may be more complicated than that of a simple correlation with outcomes however. Drawing on the same data as Myhr et al. (2007), Renaud et al. (2013) studied the relationship between positive outcome expectancy, avoidance of difficult or affect laden issues in psychotherapy (as measured by the "security operations" factor of the SSCT) and outcomes. Renaud et al. (2013) found that, whilst expectancy did not directly predict outcome, low levels of expectancy could moderate the effect of avoidance. As such amongst clients with low expectations (but not high)

lower avoidance was associated with better outcomes. The authors suggest that this may be because a willingness to engage in the more difficult aspects of psychotherapy may buffer the effects of negative expectations. This study has some limitations however, using the same data set as Myhr et al. (2007) leads this study open to the same limitations as its parent study. In particular the comparison of two five point Likert scales is unlikely to meet the parametric assumptions and it would have been interesting to see if this study would have received the same results if a non-parametric analysis had been done. Nevertheless, this study is one of few which attempted to explore the issue of expectancy/credibility in a more nuanced manor and as such is worthy of merit.

Expectancy/Credibility Summary and Synthesis.

As with the pre-existing reviews, the primary studies explored in this section suggest that the evidence for a predictive relationship between expectancy/credibility and outcomes is mixed at best, differing from results obtained in studies of wider psychotherapy (Constantino et al., 2011)

A key issue when comparing the studies above however has been one of measurement. In particular many of the studies reviewed make use of a version of Borkovec and Nau's (1972) treatment credibility questionnaire. This questionnaire, developed for measuring the credibility of treatments for public speaking fears has five questions, some about the treatment itself, some about expectations and some specifically about public speaking. Obviously, this is inappropriate for most of the studies reviewed without extensive alteration and this is done in all cases. However not all of the studies reviewed give details of what questions they are asking and those that do include questions about both expectation and credibility. Some studies (Borkovec & Mathews, 1988; Borkovec & Costello, 1993; Borkovec et al., 2002) use a three question version of the questionnaire as a measure of credibility whilst one (Steketee et al., 2011) uses a four question version as a measure of expectancy. This variation in measurement is particularly disappointing in later studies as a validated "Credibility/Expectancy" questionnaire (Devilly & Borkovec, 2000) was available.

Another difficulty when measuring expectancy and credibility is that it is very difficult (and arguably inappropriate) to measure them before the treatment has been explained. As such a number

of methods are identified for explaining treatments to participants. Fennell and Teasdale (1987) (reviewed in Ilardi & Craighead, 1994) for example measured credibility based on treatment information booklets given out beforehand. Borkovec and associates however (Borkovec & Mathews, 1988; Borkovec & Costello, 1993; Borkovec et al., 2002) all chose to administer their rating scales following an initial psychotherapy session in which treatment was explained. These, and other differences in measurement, all make it difficult to accurately ascertain a consistent relationship between expectancy, credibility and outcomes and may have contributed to the inconsistent results obtained.

As with many of the factors explored herein there is always the possibility that the strength of a predictor might relate as much to the patient diagnosis as to the treatment. This review has identified 14 studies (including those identified by other reviews) exploring treatment of anxiety disorders, of which only two (Price & Anderson, 2012; Borkovec & Mathews, 1988) identified any significant relationship between expectancy or expectancy/credibility and outcomes and one (Borkovec et al., 2002) found a relationship with credibility. Similarly the majority of studies examining depression failed to find a relationship these variables with only two (Kazdin & Kraus, 1983; Nau et al., 1974) out of the six studies identifying a significant correlation. Therefore, for both anxiety and depression there is limited evidence that expectancy/credibility predicts outcome.

However, the two most significant issues with the majority of papers identified in this section were those of reporting and sample size. The fact that many of the studies amalgamated their data, either in terms of treatment group or utilising combined measures makes it difficult to identify a specific effect for either expectancy or credibility with CBT specific outcomes. This problem is compounded by the wide range of sample sizes employed and large numbers of predictors investigated in many of the studies, limiting the power of the studies and making more difficult to identify medium or small effect sizes.

It is of note however that those that attempted to analyse high numbers of correlates without extremely large sample sizes seemed to obtain more mixed results (e.g. Borkovec & Mathews, 1988),

whilst those with higher power have been less likely to do so. This gives weight to the idea that small effect sizes may have been missed in smaller studies or those investigating more complex interactions.

It would have been ideal given the large amount of data collected to have conducted a meta-analysis of these predictors, however on closer investigation the author found, like Knopp et al. (2013), that the quality of reporting did not allow for this. It is noteworthy however that where measures have been separated there appears to be slightly stronger evidence for a credibility effect than for expectations, although there also appears to be a high degree of correlation between them. Both studies exploring the relationship between outcomes, expectancy/credibility, and other therapeutic factors (avoidance and therapeutic relationship) however appear to have shown a statistically significant effect.

It is not clear why the results of CBT specific studies should be so different to those obtained by Constantino et al. in their (2011) cross psychotherapy meta-analysis of expectations. This may be related to the Constantino et al.'s use of meta-analysis to investigate their data or differences in the quality of the data or reporting in the studies they reviewed. Alternatively, it may be a more structural difference between CBT and the other psychotherapy models employed. Whatever the reason, there appears to be limited evidence of a simple direct relationship between expectancy/credibility and outcomes in CBT for common mental health problems. Rather it appears more likely that where there is a relationship, it is probably through its impact on patient engagement in psychotherapy.

Treatment Preference

Client treatment preference, that is their decision to enter into or choose between two or more particular treatments, is a slightly different construct to that of expectations and credibility, although high levels of correlation between them have been identified (Leykin et al., 2007). The ability to choose or express preference for treatment is widely regarded as a key factor in both satisfaction with and engagement in wider health care treatment (Preference Collaborative Review Group, 2008) and a clear association between treatment preference and outcomes has been identified in a cross treatment meta-analysis of mental health care (Lindhiem et al., 2014). Given this it would be expected that

treatment preference would act as a significant predictor of outcomes in CBT. There are a number of potential difficulties in measuring preference however, as most study participants have already shown a preference for treatment by opting in and may opt out of a study in which there is a chance that they may be allocated to a treatment that they do not want (Leykin et al., 2007). Perhaps because of this, treatment preference has not been studied to a great degree, despite it being one of the minimum quality standards in at least one major service (Improving Access to Psychological Therapies, n.d).

Prior Reviews.

No prior reviews that investigated treatment preference as a predictor of outcomes in CBT were identified that met the criteria for inclusion in this chapter.

Studies

Three studies were identified by the current review, none of which identified any significant relationship between treatment preference and outcomes. As previously mentioned in the Expectations/Credibility section of this review, Leykin, et al. (2007) made use of existing data from a large multisite study (Dereubis, et al., 2005) to investigate the predictive quality of treatment preference and expectation on CBT outcomes and drop out. Leykin et al. (2007) found no significant relationship between preference and treatment outcomes. For a more thorough review of this study see the Expectations/Credibility section above.

A second study, by Dunlop et al. (2012), analysed data from a comparison trial exploring biological predictors of remission from MDD in adults randomly assigned to either pharmacotherapy (Escitalopram) or 16 sessions of CBT. 77 Participants were asked to express a preference for treatment and complete a 5 question 6 point Likert type scale detailing their beliefs about their illness and whether this affects their preference before being randomly assigned to a treatment group. Dunlop et al. did not identify any relationship between preference and outcomes or early termination rates for participants whether or not they received their treatment of preference. However, they do accept that the large number of participants expressing no preference meant it was not possible to maintain power for small effect sizes.

Similarly, Bakker et al. (2000) looked at the relationship between CBT by preference or allocation and outcomes in the treatment of panic disorder for 66 adults attending an outpatient anxiety clinic. Bakker et al. compared two treatment groups; those who were allocated randomly to CBT as opposed to medication and those who opted for CBT by refusing medication. They found no significant difference in outcomes between the preference and allocation groups on any of the 10 anxiety or depressions measures used. Bakker et al.'s pre-post study is small but still adds to the debate on the treatment preference/outcome relationship. Its main limitation with regard to this review however is that it measures random allocation verses preference for CBT (or specifically medication refusal). It does not however measure the level of preference in the randomised group. This is of import as it is not known how many of the participants in the randomised group might have preferred CBT. Secondly, whilst the authors state that participants in the preference group "had a very strong preference for psychological treatment" (pp.240-241) they also state that they were allocated to CBT due to their refusal to take medication. As such one could argue that the group identified as the preference group was instead a medication refusal group. Both of these difficulties could have been resolved by taking a rating of participants' preference for and against any given treatment before allocation.

Preference Summary.

The lack of direct evidence for a relationship between preference and outcomes might appear counterintuitive, particularly given the relationship between treatment choice, concordance, and outcomes in wider and mental health care (Lindhiem et al., 2014); Preference Collaborative Review Group, 2008). Given the mixed evidence for treatment expectations/credibility however these results are, perhaps, unsurprising. One possible explanation is that whilst treatment preference may be expected to have an initial impact on the acceptability of the treatment this effect may be overshadowed by the patient experience once psychotherapy starts. Alternatively, whilst preference might influence concordance and motivation in treatment, this might not be enough in itself to have a significant impact on psychotherapy outcomes. Small sample size is again an issue with two of the three studies above, which may also have affected the results when looking for small effects. It is also

of note that none of the above studies measured degree of preference, only direction. Given that preference, like motivation, could be best regarded as a sliding scale this is a significant impedance to discovering if a significant relationship with outcomes exists.

Beliefs about illness

The reasons to which individuals attribute their mental health problems are diverse, including such causes as cognitive factors, interpersonal problems, biological factors and experiences (childhood or current) (Addis, Traux & Jacobson, 1995; Elkin et al., 1989). They have also been shown to both be influenced by previous experiences of psychotherapy and to affect people's treatment preferences (Dunlop et al., 2011; Khalsa, McCarthy, Sharpless, Barrett, and Barber, 2011).

Studies

Three primary studies and no reviews, investigating the impact of patient beliefs about their illness were identified. The first of these studies, Dusseldorp et al. (2007) drew on data from Bakker et al.'s (1999) comparison of antidepressant medication (AD) and CBT in the treatment of 129 adults with panic disorder, 32 of whom were assigned to a CBT group. Dusseldorp et al utilised a Regression Trunk Approach (RTA) (Dusseldorp & Meulman, 2004) to data analysis to explore whether participants' beliefs about the locus of control (LOC) of their panic attacks was a differential predictor of outcome between AD and CBT. LOC, which is related to an individual's perception that events are either attributable to external causes (external LOC) or their own agency (internal LOC) (Erickson, 1983), is regarded as central to both an individual's vulnerability to anxiety and to the psychotherapy process (Thompson & Wierson, 2000).

Dusseldorp et al. hypothesised that participants with a high internal LOC would achieve superior outcomes in CBT for their panic disorder compared to those with low. However, the results indicated that those with medium levels of internal LOC performed better than either the high or low internal LOC participants. These results were enabled by the author's use of RTA analysis. One of the challenges of commonly used correlation analyses is that it assumes a linear relationship. Dusseldorp et al.'s use of RTA allowed them to identify a u-shaped relationship. The authors suggest that results

may have differed from their hypothesis due to individuals with high internal LOCs having unrealistic views of their ability to control their panic, leading to setbacks in psychotherapy when they are initially unable to do so.

Dusseldorp et al.'s decision to focus on participants' beliefs about control over their panic attacks rather than their generalised LOC may have been a complicating factor in this study and was the reason for its inclusion in this section rather than that of *personality* (below). The cognitive model of panic disorder implies that a key factor in panic attacks is a sense of loss of control of one's body, as the physical sensations associated with a heightened anxiety state are misinterpreted as harmful, dangerous and out of control (Clark, 1986). Consequently, it is possible that the symptoms of loss of control would interact significantly with the patient's beliefs about their own LOC, making it difficult to generalise the findings of this study to other diagnoses. It would be particularly interesting however to see this study replicated to explore the impact of a generalised LOC measure with other disorders.

A second study (Dunlop et al., 2011) (discussed above) studied the relationships between treatment preference, beliefs about causes of illness and outcomes for 66 adults with MDD. In order to investigate the beliefs component of this trial, Dunlop et al. administered an adapted version of the Patient Attitudes and Beliefs Scale (Elkin et al., 1989). These included; biological (brain substance), pessimistic thoughts, stressful life events, "out of the blue", and an identification of MDD as an "emotional illness". The authors found no relationship between any beliefs patients held about the causes of their depression and outcomes of CBT. However, they found that patients who preferred CBT rarely endorsed unknown causes for their depression whilst those who professed a preference for medication tended not to identify pessimistic attitudes as the source of theirs. Whilst this did not impact on outcomes in this study, the authors identified that participants who endorsed pessimistic attitudes as a cause of their illness were more likely to complete treatment. They suggest that this may relate to an increased acceptance of responsibility for the illness, leading to increased motivation.

Finally, in the previously described study by Vittengl et al. (2019) (see expectations section), data from a study of acute and continuation phase CBT (Jarrett & Thase, 2010) were analysed to

investigate whether participants' expectations of therapy outcome or beliefs about the nature of their depression were predictive of symptom outcomes. In order to investigate participants' pre-treatment beliefs about the nature of their depression, Vittengl et al. measured Likert type responses to a number of pre-treatment questions relating to beliefs about biological, cognitive or interpersonal causes and carried out regression analysis to see if scores on these questionnaires predicted symptom outcomes at either the acute or continuation stage of therapy. Vittengl et al. found that whilst pre-treatment beliefs about depression being due to cognitive or interpersonal factors did not predict outcomes, participants who expressed weak beliefs that their depression was due to biological factors achieved improved post therapy outcomes in both the acute and continuation stages of the study than those who expressed strong beliefs in the biological nature of their depression.

Beliefs about illness Summary

Individual's beliefs about their illnesses can be so broad as to make it difficult to draw conclusions. Of the papers identified here, two are investigations regarding the believed causes of depression and one is about perception of control in panic disorder. Of the former only one factor was identified as potentially relevant, that of weak beliefs about the biological nature of depression. This result is particularly interesting given that the strength of beliefs about depression being a result of cognitive or interpersonal factors did not predict outcomes. However, it could be argued that the detail of beliefs about any psychosocial factors are less important to engagement in therapy than the strength of belief in biological causes, as biological causes might be seen as less susceptible to therapy.

The concept of control, whether over one's illness or more generally is equally interesting and Dusseldorp et al.'s identification that a belief in one's ability to retain control of one's life or symptoms may not always relate positively to treatment outcomes is also worthy of further investigation.

Interpersonal styles/distress

Interpersonal style is a nebulous concept that could best be described as the way we relate to others. Similarly interpersonal problems may be regarded as difficulties in doing this. The literature

search highlighted two key issues that limited the number of studies included in this section. First, whilst there have been a number of studies investigating the relationship between interpersonal factors and the therapeutic relationship (e.g. , Connolly-Gibbons et al., 2012; Muran et al., 1994) many have not related their results to outcomes. A second issue when measuring client interpersonal distress as a pre-treatment predictor of outcome is that a number of studies identified measured such factors during the course of psychotherapy (e.g. Castonguay et al., 1996) as opposed to before the commencement of treatment. Pre-treatment interpersonal styles are, by their nature, unaffected by the course of therapy however it is possible that interpersonal behaviour may change during the course of treatment. Pre-treatment interpersonal styles may also be more indicative of people's lives outside of the therapeutic relationship, a factor that has been identified as potentially contributing differently to the psychotherapy process to in treatment behaviour (Renaud et al., 2014). Whilst pre-treatment interpersonal problems are still likely to relate to an individual's interaction with their therapist it could be hypothesised that they may offer a more global impression of an individual's means of interacting with the wider community than specifically measuring their interaction in the therapeutic space. For this reason and in line with the boundaries of this review to investigate only pre-treatment predictors of therapy, only studies of interpersonal style that collected data before the commencement of therapy were included.

All of the studies that were identified in this section, utilised a version or derivative of the Inventory of Interpersonal Problems (IIP-127) (Horowitz et al., 1988). The IIP-127 is a highly robust 127 question self-report questionnaire designed to measure distress from interpersonal sources. It has high internal consistency, test-retest reliability and sensitivity to clinical change (Horowitz et al., 1988). The IIP-127 has been modified on a number of occasions, however. In particular, the Inventory of Interpersonal Problems—Circumplex Scale (IIP–C) (Alden et al., 1990; Horowitz et al., 2000) is a shortened 64 question version that utilises eight subscales (Domineering/Controlling, Vindictive/Self-centred, Cold/Distant, Socially inhibited, Non-assertive, Overly accommodating/exploitable, Self-sacrificing/overly nurturant, and Intrusive/Needy) arranged into octants. These octants relate to the "Circumplex" model of interpersonal behaviour (Horowitz et al., 2006; Renner et al., 2012), which

rates individuals on a two axis scale of agency (domineering/non-assertive) and communion (overly nurturing/cold). This has been well validated in terms of its ability to measure interpersonal problems based on the Circumplex model (Alden et al., 1990) but has been shown to demonstrate poor convergence with external/observer ratings of personality traits in (Leising et al., 2007).

Most of the studies identified investigated the treatment of MDD. Individuals with MDD have been shown to display significantly greater levels of distress in response to interpersonal problems than a normative sample (Barrett & Barber, 2007). Barrett and Barber (2007) found that a sample of 141 individuals with MDD reported significantly higher levels of difficulty in the areas of social avoidance/inhibition, vindictiveness, coldness, or non-assertiveness on the IIP–C. They also found that their participants scored significantly lower than the norm in questions relating to difficulties with nurturing. This was partially corroborated by Renner et al. (2012) who found that individuals with MDD were more likely to have difficulties relating to being socially avoidant, non-assertive, and exploitable on the scale, but were less likely to be intrusive, domineering or vindictive.

Prior Reviews

No prior reviews were identified investigating the relationship between client interpersonal styles and outcomes in CBT.

Studies

As part of a study of whether therapist styles changed in relation to client interpersonal styles in CBT and PT for depression Hardy et al. (1998) analysed the relationship between interpersonal distress, measured pre-treatment and treatment outcomes at post psychotherapy, 3 month and 12 month follow up. Hardy et al. modified the IIP-127 to classify respondents into the categories "overinvolved", "underinvolved" and "balanced" based on Bowlby's (1988) anxious-ambivalent, avoidant and secure attachment styles. They found no significant relationship between interpersonal style and outcomes for either treatment group or at any stage of assessment. This study was relatively robust, with a reasonable sample size (n=117) for its analysis. Some questions might be asked over the author's decision to include experienced but non CBT or psychology qualified practitioners in

their therapist group, however. Whilst they monitored treatment fidelity, the level of competence of the therapists involved in the study cannot be verified through level of external training in CBT or membership of an accreting CBT body. Consequently, the level of competence of therapists in Hardy et al.'s (1998) study could have affected their results, particularly given that they were measuring therapist behaviour. The relationship between therapist training and competence is discussed at length in Section 2 of this thesis. Another factor that may have affected the results relates to the authors' decision to adapt the IIP-127, whilst conscientiously done, may have impacted on the validity of the measure.

Hardy et al. (2001) built on these results in order to explore the relative contribution of cognitive and interpersonal functioning to outcomes in CBT for depression. They used the IIP-127 to provide a 14 item "underdeveloped" scale and a 7 item "overdeveloped" scale of interpersonal style based on Hardy et al.'s (1998) analysis. Hardy et al. (2001) revealed a significant correlation between underinvolved interpersonal style and poorer outcomes that was meditated by the therapeutic relationship. Whilst overinvolved style initially correlated with outcomes this was factored out in subsequent analysis of covariance. Unlike Hardy et al. (1998) this study utilises qualified therapists and psychologists to conduct treatment. Whilst it suffers greatly in its power (n=24) its results indicated a relationship between interpersonal style and outcomes that the three other (larger) studies utilising the IIP-127 did not.

Saatsi et al. (2007) attempted to build on Hardy et al.'s (2001) study with a larger sample size (n=97). They utilised first Hardy et al.'s (1998) adaptation of the IIP-127 and then Attachment Vignettes (AV) (Hazan & Shaver, 1987) to categorise participants into either secure, insecure avoidant or insecure ambivalent attachment groups. They then explored the hypotheses that participants with secure attachments would achieve better outcomes in CBT for depression than those with insecure attachments and that this would be mediated by the therapeutic alliance. Saatsi et al. (2007) found that participants with secure attachment styles responded significantly better than those with either insecure avoidant or ambivalent styles. 93.3% of those with secure attachments achieved clinically significant change, with secure attachment contributing to 6.6% of the variance in outcome.

Mediator analysis of the relationship between secure attachment style and outcomes indicated that this was mediated by the therapeutic alliance. There was no significant difference in outcomes between the two insecure groups and data from these did not contribute significantly to overall variance in outcomes, although the proportion of participants achieving clinically significant outcomes was slightly higher for the avoidant group (52.5%) than for the ambivalent group (38.5%).

There were a number of limitations to this study, however. First due to administration changes the study design changed mid trial, with session being reduced from 12-20 to 12 and two of the predictor measures being changed. Additionally, the attachment measure was changed from the IIP-127 to the AV, and the therapeutic alliance measure, was changed from the California Psychotherapy Alliance Scale (Marmar & Gaston, 1998) to the Agnew Relationship Measure (Agnew-Davies et al., 1998). A second possible issue was power. Despite the large sample size, the attachment groups were not equal in size with 40 participants in the avoidant group, 26 in the ambivalent group and only 15 in the secure group. Whilst this is understandable, given the naturalistic design, in which attachment style was measured post admission to the study, the low number of participants in the secure group may have affected findings.

In another study, McEvoy et al. (2014) used a 32 question adaptation of the IIP-127 (IIP-32) (Barkham et al., 1996) to explore the relationship between interpersonal problems, alliance, and outcomes across individual and group CBT (CBGT) for depression and anxiety. They found significant differences in the relationships between the two treatment groups, with the higher IIP-32 scores being associated with poorer outcomes and high dropout in the CBGT group but not the individual CBT. This pre/post, study benefits from a robust, uncomplicated analysis but displays many of the methodological difficulties when undertaking naturalistic studies. The authors concede that primary amongst these is that participants were allocated to treatment groups by screening professionals within a healthcare service rather than by random allocation. This gives rise to a number of possible confounds, not least of which is the fact that allocation criteria are not identified and are implied to be subject to the opinion of screening professionals. The inclusion of clients with more than one disorder is also a possible difficulty, in terms of the specificity of the results and the manor

and focus of treatment, particularly in individual CBT. Sample sizes (N=199, *n*(group)=115, *n*(individual)=84) are also not sufficient do detect small effect sizes in some analyses. Finally like many studies of its kind there is a lack of follow-up of non-completers. Whilst this is not uncommon in naturalistic studies it is of potential import in studies exploring patient characteristics in particular, as the reasons for dropout may be related to effects of the predictors measured.

In their (2002) dismantling study of CBT for GAD (discussed above) Borkovec et al. used the IIP–C in their component analysis of CBT for GAD. The authors identified that higher levels of overall pre psychotherapy interpersonal problems were related to poorer outcomes post psychotherapy. However only 6 of a possible 32 correlations between the 8 IIP-C subscales and the four post psychotherapy and follow up assessments were significant. After Simes' Bonferroni adjustment these reduced to 3. These were Domineering/Controlling, Vindictive/Self-centred and intrusive/needy, each of which correlated with depression outcomes at 6 month follow up.

As discussed a number of adjustments have been made to the IIP-C and IIP-127. Of note, Renner et al. (2012) built on work by Vittengl et al. (2003) to factor out levels of general distress from the IIP-C. Renner et al. (2012) maintained that a major problem with the IIP-C is that it is difficult to distinguish between interpersonal styles and the distress related to illness. Renner et al. developed a three factor model of agency, communion and distress, hypothesising that participants in their sample of 523 adults undertaking CBT for depression displaying high levels of communion related personality traits would develop stronger therapeutic alliances, and thereby benefit from better outcomes, whilst those displaying hostile/dominant (high agency) traits would develop less helpful therapeutic alliances, contributing to worse outcomes. Their hypotheses regarding the therapeutic relationship were born out, with high agency relating to poor relationship and high communion corresponding to strong relationship but communion was not significantly related to outcomes, contradicting their hypothesised relationship between alliance and outcomes. Contrary to their expectations the authors found a borderline significant (p=0.06) relationship between high agency scores and better outcomes post psychotherapy. Renner et al. suggest that a possible explanation for their unexpected results was that previous research on which their hypothesis was based utilised a

simplified structure to their data and did not account for changes in distress levels. An alternative explanation however might be the fact that some of the previous studies they cite are either of participants with a diagnosis of personality disorder (Alden, & Capreol, 1993) or were studies of psychodynamic psychotherapy (Gurtman, 1996). It is possible that the additional affect management difficulties experienced by people with personality disorders could have led to different results in the former study whilst it is easy to hypothesise that someone with a dominant/agency led personality might have a different experience in the more active and structured CBT than they would in psychodynamic psychotherapy.

Interpersonal Styles Summary

Given the reasonably high number of studies in this area and the broad evidence for a relationship between interpersonal attachment style and outcomes in wider psychotherapy (Levy et al., 2011) it is perhaps surprising that the evidence for a relationship between interpersonal style and CBT outcomes remains mixed.

Of the six studies identified, four identified some sort of relationship with outcomes and two did not. From those that did, there are a number of relationships to explore. Hardy et al. (2001) found that interpersonal styles associated with insecure (particularly avoidant) attachment predicted poorer psychotherapy results, whilst Saatsi et al. found those associated with secure attachments predicted better. Similarly Borkovec et al. found that overall IIP-C scores (indicating high levels of interpersonal problems overall) were associated with poorer outcomes. These results correlate reasonably well with Levy et al.'s (2011) meta-analysis of attachment in psychotherapy. Two particularly contradictory results stand out however. Borkovec et al. (2002) identified that Domineering/Controlling, Vindictive/Self-centred and Intrusive/Needy interpersonal styles all predicted a poorer response to CBT. In contrast Renner et al. (2012) found that only Domineering styles predicted better outcomes. Of these studies, the one conducted by Renner et al. appears to stand out as having incompatible results to the others. As the authors point out however they made

significant adaptations to the IIP-C, perhaps making it difficult to compare their results to the other studies.

The use of the IIP-127 and its derivatives is both a strength and a potential weakness of the above studies. The IIP-127 and IIP-C are both well validated (Alden et al., 1990; Horowitz et al., 1988) and the use of a broadly common psychometric makes comparisons between studies simpler, but the frequent adaptations to the scales made in the above studies may lead the reader to make comparisons that are not in fact based on the evidence. Additionally the poor convergence between the IIP-C and external observer ratings of personality (Leising et al., 2007) is a possible drawback. Overall the evidence for a relationship between interpersonal style and outcomes in CBT is mixed, with high levels of interpersonal difficulties being related to poorer outcomes in most of the studies identified. However the precise nature of this relationship remains difficult to determine due to a lack of concordance between outcomes. There is some evidence that where a relationship between interpersonal styles and outcomes does exist it may be mediated by the therapeutic relationship.

Personality

Personality is perhaps the most difficult to define of all the predictors presented in this review and its definition (or even its existence) remains the source of much debate in personality psychology literature. Perhaps the most commonly used (Funder, 2001) conceptualisation of personality, the *Five Factor Model* (FFM) (Costa & McCrae, 1989), (sometimes known as the big five) is made up of the five domains of Neuroticism, Extraversion, Openness to experience (Openness), Agreeableness and Conscientiousness. However personality is interpreted though, the way in which people think about and respond to their environment and themselves has long been regarded as a key factor in psychotherapy (Bohart & Wade, 2013).

Prior Reviews

No prior reviews investigating the relationship between personality and CBT outcomes were identified that met the criteria for inclusion in this review.

Studies

Four studies were identified that covered the relationship between personality and outcomes in CBT. Bagby et al. (2008) used the NEO Personality Inventory – Revised (NPI-R) (Costa & McCrae, 2008) to examine the association between the FFM personality traits and outcomes in both CBT and AD treatment for depression. They used hierarchical linear regressions for each of the five domains and their thirty facet traits. There were no significant differences in outcomes between the treatments and the study indicated a significant main effect for the domain of Openness, which was associated with better treatment outcomes across both treatment groups. Six further significant effects were identified for the personality facets. Four facets of the Openness domain, fantasy, aesthetics, actions, and values were all individually associated with lower depression severity post treatment. Two facets of the Extraversion domain; excitement seeking and positive emotions, were also associated with better outcomes but did not remain significant after controlling for other personality factors. High levels of neuroticism were associated with lower post treatment depression in AD compared with CBT. Five individual facets of the Neuroticism domain were included in this interaction, but these did not remain significant when controlling for one another, suggesting that this is an overall domain related interaction rather than one based on any particular facets. From the Agreeableness domain the facets of trust, straightforwardness, and tendermindedness were all significantly related to differential scores between treatments, with trust and straightforwardness being associated with better scores in CBT and tendermindedness being related to better outcomes in AD. Bagby et al.'s (2008) study adds to the discourse on personality effects in CBT, although the fact that main effects were true for both CBT and AD treatments implies that these are not CBT (or even psychotherapy) specific factors. The statistical analysis is appropriate and robust with the authors accounting for a large number of covariates, and identifying areas that they were not able to investigate due to the limitations of statistical power (n=280).

The NPI-R is not the only measure used in the analysis of personality however. Mortberg and Andersson (2014) explore personality effects in their comparison of individual and group CBT treatment of Social Phobia. Amongst other variables they look at the predictive effect of "self-

directedness" as measured by the Temperament and Character Inventory (TCI) (Cloninger et al., 1994). This is made up of five components, Responsibility, Purposeful, Resourcefulness, Self-acceptance and Congruent Second Nature; and according to the authors relates to "self-directedness and willpower and the ability to control, regulate and adapt one's behaviour" (pp.36-37). Owing to the small sample size in this study the authors restricted the number of predictor variables they analysed, treating their self-directedness measure as a single score. They found that this significantly positively correlated with CBT outcomes at post psychotherapy but not at one year follow up in both individual and groups treatments. This small study (N=54, n(individual CBT)=28) gives some weight to the argument that self-control and internal LOC are positive predictive factors in CBT (recall that LOC was also investigated by Dusseldorp et al. (2007) but that due to the focus on locus of control of symptoms this study was included in the beliefs about therapy section). The authors wisely made a decision to investigate a limited number of predictors based on their small sample size (anticipatory worry, fear of negative evaluation, presence of cluster C personality disorder and self-directedness) and clearly evidence their decision making process in choosing them. However these factors could be regarded as somewhat disparate in that two of these (anticipatory worry, fear of negative evaluation) are core components of social phobia and a third (the presence of cluster C personality disorder) is an indicator of comorbidity. There is an argument therefore given the low power of this study that it would have been of greater import had it focused on a more specific area of prediction in greater depth.

An area that relates strongly to personality, but is not directly measured through one of the FFM is that of affect regulation. Whilst this could have been included as its own section, this relationship led to it being included as part of the personality category.

Two studies focus specifically on exploring the relationship between affect regulation and outcomes in CBT. The first (Gunthert et al., 2005) investigated the relationship between daily stressors and negative affectivity (NA), coping styles, and negative automatic thoughts to try and predict changes in symptom severity during CBT for a wide range of affective disorders. Gunthert et al. (2005) asked participants (n=43) to complete daily diaries for a week between the first and second

psychotherapy session, recording their most stressful daily event and appraising it in terms of its controllability and undesirability. They also rated their mood using the Positive and Negative Affect Scale (PANAS-X) (Watson & Clark, 1994). Rather than analysing the pre/post variation in their symptom outcome measures, the authors utilised longitudinal growth modelling to establish the trajectory of change in symptoms over treatment. Faster rates of symptom change over the course of therapy were identified for those participants who experienced lower levels of NA change in response to events they appraised as undesirable, and who perceived themselves as being more capable of coping at the start of psychotherapy. This study has a number of limitations, many of which are identified by the authors. Firstly, the decision to accept subjects from a range of affective disorders rather than just one may be justified in terms capturing an acceptable sample size but makes it more challenging to generalise the results to any specific diagnosis. Second, authors accept that their decision to collect data after the first psychotherapy session rather than pre-treatment was not ideal. Third, the use of diaries did not allow for monitoring of when the data were recorded, and an assumption was made that it was completed by participants at the time they were requested to. Finally, even if the data were collected 100% appropriately by participants, the decision to collect it once per day led to a danger of retroactive bias in reporting.

Many of these limitations were resolved in a follow up study (Cohen et al., 2008) involving most of the same researchers. Cohen et al. (2008) explored how the ability of individuals with MDD to recover from NA inducing stressful life episodes on a day by day basis can affect early and late treatment response. For one week prior to treatment commencing Cohen et al. asked participants (n=62) to complete a nightly automated interview based on the PANAS-X in order to assess their responses to daily stress. Rather than exploring straight pre/post measures of symptom change, Cohen et al. measure rate of change in early (sessions 1-4) and late (sessions 5-12) stages of CBT treatment. Contrary to expectations, NA in response to stressful life events did not predict rates of change in either early or late psychotherapy. However, the study did identify a significant correlation between NA the day *following* a negative life event and early treatment response. The authors suggest that this

NA “spill over” may be related to individuals’ ability to recover from life events rather than their initial reaction to them.

This is an interesting and well conducted study, which, due in part to its creative method adds significantly to the debate. The authors take pains to address a number of the possible confounds identified in their previous study by limiting participants to a specific diagnosis and recording computerised interviews rather than relying on participants’ diaries. There are however still some limitations. Chief amongst these is the length of treatment, which was between 3 and 83 sessions (mean=12.7, SD=10.6). Whilst the authors did control for this in their analysis, it is difficult to argue that sessions 5-12 comprise “late sessions” in a treatment that lasts 83. The wide disparity between the possible lengths of treatment could also have affected the nature of psychotherapy as 3 sessions of CBT looks quite different to that conducted over 83 sessions. The authors are robust in their critique of their paper however, acknowledging a number of other limitations including the lack of control group and the effect of mood related retroactive bias when conducting end of day rather than at the time reporting.

Personality Summary

Given the level of historic import that the field of personality has had in psychology it is perhaps surprising that so few studies were identified in this area. Overall evidence for some form of relationship between client personality and outcomes is strong. However comparison of those studies investigating *personality types* is difficult due to the different constructs used. It could be suggested that Mortberg et al.’s identification of a relationship between self-directedness and outcomes is only partially reinforced by Bagby et al.’s results, given that self-directedness might be better associated with their domains of extraversion and conscientiousness as much as to openness. It is also important to note that the FFM domain of *Openness* relates to *Openness to Experience* rather than willingness to disclose.

The studies of emotional reactivity demonstrate a link between negative affect reaction to stressful life events and outcomes. Given that Gunthert et al.’s findings were not specifically

replicated by Cohen et al. however the process underlying that relationship would benefit from further research.

Multi factor tools

Only one multi factor tool has been developed to attempt to predict the relationship between client psychological factors and outcomes in CBT. The Suitability for Short Term Cognitive Therapy Scale (SSCT) (Safran et al., 1990) was developed by drawing on studies of assessment procedures for short term psychodynamic psychotherapy and on Bordin (1979) development of the concept of therapeutic alliance. The SSCT utilises a practitioner rated semi structured interview to assess a range of patient factors that, they posit, impact on treatment outcomes. The scale uses an anchored five point Likert scale to rate patients':

1. Accessibility of automatic thoughts
2. Awareness and differentiation of emotion
3. Acceptance of personal responsibility for change
4. Compatibility with the cognitive rationale
5. Alliance potential in session
6. Alliance potential out of session
7. Chronicity
8. Security operations &
9. Focality (i.e. ability to focus to a specific problem)

(Safran et al., 1990, pp231-232)

Studies

Safran et al. (1993) attempted to validate the SSCT for the treatment of anxiety and depressive disorders. They administered the SSCT to 64 people referred to their treatment centre. Following this, 42 were accepted into CBT treatment and 22 referred elsewhere. The authors examined the construct validity of the questionnaire by comparing it with the Working Alliance

Inventory (WAI) (Horvarth & Greenberg, 1989). The only factor that correlated with this was Alliance in Session, indicating that all other factors were measuring a different construct to the WAI. The authors identified a significant relationship between mean SSCT score and outcomes, indicating the predictive validity of the test. This study represents a successful attempt to develop a validated predictive tool to explore the relationship between client suitability for CBT and treatment outcomes. However, it has a number of limitations. First, perhaps due to the low sample size, the authors chose not to investigate the relationship between the individual factors of the SSCT. This is of particular import as the criteria were developed through "theory, observation of intake interviews and evaluation of clinical outcome" (p.26), rather than clinical studies. Whilst this is understandable given that this was the first study of its kind in CBT, this perhaps made it more important to attempt to explore the components of the measure individually. Secondly the authors chose their treatment and non-treatment groups following clinical interview, in which the SSCT was administered. Whilst they state that the SSCT was not used in the decision making process the lack of randomisation in these groups is of possible impact.

Myhr et al. (2007) (discussed above), attempt to rectify Safran et al.'s lack of investigation of the individual factors of the SSCT by conducting a dismantling study involving 113 adults with MDD. They administered a 10 question version of the SSCT, including the term optimism/pessimism about psychotherapy, which Safran et al. (1993) did not include, and a 5 point anchored self-report Likert scale, to ascertain participants "Hopefulness about CBT". Myhr et al. analysed the contributions of each factor individually to changes in outcomes, as measured by the Reliable Change Index (Jacobson & Truax, 1991). Their results indicated a high correlation between outcomes and mean SSCT scores, as well as with the factors awareness and differentiation of emotion, acceptance of personal responsibility for change, alliance potential (in and out of session) and security options.

Myhr et al. (2007) produce an interesting exploration of the SSCT. Their results do much to further validate the only CBT specific outcome prediction measure, but in dismantling it they potentially fall into the trap of reducing their data's concordance with the parametric assumptions. The authors use hierarchical linear regression to analyse the data from 10, anchored 5 point Likert

scales, measuring all of the factors in the SSCT. Whilst it may be argued however that the volume of data contributing to the overall score (i.e., 10 times 5 point Likert scales) is enough to broadly meet the parametric assumptions it is more difficult to argue that comparing these scales individually to outcomes does (Jamieson, 2004). Despite its relatively large sample size this study also falls into the trap of analysing large numbers of correlates reducing the ability to identify smaller effect sizes and increasing the chances a type 1 error. Whilst their data analysis would have factored out a degree of covariance in their results Myhr et al. do not address this directly. In particular, their study would have benefited from an exploratory factor analysis of the SSCT scale, had sample numbers allowed.

The issue of factor analysis was later addressed by Renaud et al. (2014). This paper seeks to identify both the underlying constructs of the measure and their relationship to outcomes. Renaud et al. (2014) interviewed 256 adults with a combination of anxiety and depressive disorders using the SSCT before offering individual CBT sessions. Subsequent factor analysis of the SSCT results indicated two factors, which accounted for 68.7% of variance in SSCT scores. These were: (i) Capacity for participation in CBT, made up of Security operations, Accessibility of automatic thoughts, Awareness of different emotions and Focality; and (ii) Attitudes Relevant to CBT Process, made up of Optimism/Pessimism, Acceptance of responsibility for change, Compatibility with cognitive rational and Alliance potential - out of session. Alliance potential - in Session was associated with both factors to an equal degree and perhaps understandably, due to its different focus, chronicity was not associated with either factor and was omitted from further analysis. Multiple regression analysis was then conducted with the result that only Capacity for participation in the CBT process was found to significantly predict outcomes. This study does much to explore the underlying predictors that contribute to the SSCT's ability to predict outcomes and avoids the trap of engaging in large numbers of correlates. It has some limitations however, which have been identified by the authors. Firstly, the fact that the majority of treatment was conducted by trainees could have significantly impacted on both outcomes and the impact of particular predictors. An experienced therapist may, for example, be able to form a better therapeutic relationship with a patient with low in session alliance potential than an inexperienced one or may be able to encourage an individual with

more rigid security operations to be more expressive in psychotherapy. Secondly, whilst the factor analysis design avoids the multiple correlate problem the authors accept that they were not able to analyse the relative contribution of each predictor within the two factor groups making it difficult to ascertain the relationship between outcomes and the individual components of the SSCT.

Multi factor tools summary

As an overall predictor of outcomes, the SSCT has been validated by both Safran et al. (1993) and Myhr et al. (2007). The question of what aspects of it are predictive still remains open however. The individual predictors associated with Renaud et al.'s (2014) factor, capacity to engage in CBT, which correlated with outcomes, are those that could be regarded as core to the general psychotherapeutic process, those of willingness and ability to engage, accessibility of thoughts and emotions, and ability to focus although accessibility of thoughts and emotions could be seen as CBT specific. Renaud et al.'s (2014) factors only slightly overlap with the individual predictors identified by Myhr et al.'s (2007) dismantling study however, which identifies the acceptance of personal responsibility for change and alliance potential out of session as additional predictors and did not identify a relationship between outcomes and focality or accessibility of automatic thoughts. One possible explanation of the differences between these two sets of results is that they used very different statistical analysis. Whilst Myhr et al. (2007) attempted to discover the relationship between individual predictors in the SSCT and outcomes, Renaud et al. (2014) used exploratory factor analysis to identify two factors associated with the scale. Whilst it is tempting to treat all of the predictors associated with the factor, capacity to engage in CBT, which correlated with outcomes, as individually evidenced predictors it is not possible to do so. As such the comparisons between Myhr et al.'s and Renaud et al.'s studies can best be regarded as exploratory and would benefit from further investigation.

Despite its predictive validity, the SSCT suffers from an issue with practicability, however. Its semi structure interview format makes it difficult to use in a high pressure clinical service such as

IAPT, where every session is counted and therapists can rarely argue for additional time in assessment.

Discussion

The aim of this review was to investigate the findings of quantitative CBT studies of client psychological predictors of outcomes for common emotional disorders. Systematic searches of reviews and primary studies were conducted using both the Pychinfo and Web of Science databases, due to the large amount of research in this field and the fact that the pre-existing review data were dispersed throughout a number of reviews on related subjects.

Two predictors, Dysfunctional Attitudes and Motivation were identified as having strong evidence from pre-existing reviews and were not explored further. A further five factors; Expectancy/Credibility, Treatment preference, Beliefs about illness, Interpersonal styles/problems and Personality were identified following detailed analysis of 26 studies. A further category, Multi-factor tools contained studies related to only one tool, that of the SSCT.

The gold standard of quantitative review analysis is meta-analysis. However the wide variation in topics investigated, measures utilised and methods of report of the studies reviewed makes this inappropriate and impossible. In order to gain insight into the relative evidence, the number of studies showing evidence for and against each predictor category has been shown in Table 4. Predictors have been rated on a scale of 0-5, with 0 representing no evidence of correlation with outcomes and 5 representing very strong evidence. Ratings were based on number of studies finding and not finding evidence for a relationship and narrative assessment in the results section.

Table 4

Areas of evidence: individual predictors

Rank	Factor	No. Studies showing evidence for a relationship with outcomes	No. Studies showing no evidence for a relationship with outcomes	Rating of Degree of Evidence for a relationship with outcomes 0-5
1	Personality	4	0	5

2	Interpersonal Style/Problems	4	2	3
2	Beliefs about illness (control)	1	0	2
5	Expectancy/Credibility	5 (2)	5 (8)	1
6	Beliefs about illness (causation)	1	1	1
7	Preference for Treatment	0	3	0

() Evidence from studies identified in prior reviews is marked in parenthesis.

Drawing comparisons between the multifactor SSCT studies and those with a more specific focus is difficult. Some of the Predictors identified in the SSCT appear to relate to the predictive categories identified in this review. Optimism/pessimism about therapy for example is a very similar construct to expectancy/credibility; similarly, alliance potential (in and out of session) could be regarded as related to interpersonal styles. Given the ongoing difficulties in comparing different measures of the same factor within this review however, and the fact that much of the evidence within the SSCT studies is based on factor analysis it does not seem appropriate to draw these comparisons in anything more than broad strokes.

The results of this review concur in a number of areas with evidence from broader psychotherapy trials. Areas such as emotional experience and regulation (Bohart & Wade, 2013) and attachment style (Bohart & Wade, 2013; Levy et al., 2011) for example, which could relate to the predictor categories of personality and interpersonal styles respectively, have both been shown to relate to therapeutic outcomes in psychotherapy. Similarly, the results from the SSCT trials appear to indicate a stronger relationship with outcomes for some factors that might be regarded as applying to multiple models of psychotherapy, such as ability to access thoughts and emotions, willingness to engage with distressing thoughts and experiences and ability to form relationships, than for more CBT specific factors such as compatibility with the cognitive rationale. In other areas however the results of this review are surprising. The relationship between outcomes and patient expectancy, for example, appears to have a stronger evidence base in cross modality psychotherapy studies (Constantino, Arnkoff et al. 2011) than identified in this review. Issues with reporting, study design and method

identified in many of the studies reviewed however mean that clear conclusions cannot be drawn as to whether this is due to the absence of a relationship or just an inability to find one, particularly given that some evidence was found for most of the factors reviewed.

A number of common issues were identified across many of the studies reviewed in this chapter. Firstly, none of the studies identified in this review were randomised control trials of predictor variables, meaning that where a relationship has been identified it cannot be regarded as causal. Low power, either due to small sample size or the investigation of large numbers of predictors also raises difficulties, increasing the likelihood of a type two error, particularly when looking for small effect sizes. The problem of large numbers of correlates also increases the risk of type one error as the chance of random data being identified as significant increases, though a number of studies address this through the use of additional statistical tests such as Bonferroni's adjustment. All of the studies reviewed were clear about the demographic makeup of their participant groups. However, whilst demographic factors have been shown to have little or no effect on outcomes, the fact that the majority of these studies were conducted in America or Europe implies a western cultural bias. It is difficult therefore to hypothesise about whether predictors have the same impact across cultural and demographic groups. This review also has limitations. For example, it is possible that many of the predictors identified may relate to each other, however as they have often been identified in different trials, analysis of covariation has not been possible. This is one area in which larger, multi predictor studies such as Myhr et al. (2007) have particular strength. Predictor factors which include multiple, loosely related predictors, such as "personality" are also more likely to reveal evidence of some form of relationship even though the nature of that relationship is a lot less well defined than for more specific factors, such as expectancy. Perhaps most importantly the variety of measure used to explore the same factors has made it very difficult to compare results in some areas.

Overall, this review has identified mixed evidence for a small number of predictors of outcome in individual CBT for common anxiety and depressive disorders. Whilst some predictor factors have a strong evidence base, others such as expectancy/credibility and beliefs about illness have almost equal studies identifying an effect as not. Whilst this may have been related to issues

such as sample size and measurement differences there were enough large studies, using similar measures that identified very different results to suggest that whilst there is likely to be some form of relationship with outcomes in this area it is likely to be more complex than a simple, direct one.

Perhaps most the most surprising result of this review was that, of the three studies exploring treatment preference, none found a significant relationship with outcomes. However, a key issue with these studies was that they all investigated direction of preference rather than degree, making it difficult to identify a subtle relationship with outcomes if one existed. Whilst there are other reasons to encourage those undergoing therapy to make active treatment choices, such as overall satisfaction with the intake process and quality of service, the fact that no evidence was found indicating a relationship with outcomes raises the question of whether the time and resources applied to encouraging choice of treatment are well spent.

The main implication of this review for therapists and services is the identification of a number of areas to focus on in therapy and supervision, in addition to treatment protocol. Whilst evidence for the majority of these predictors is mixed it is probable that time spent building treatment credibility through psychoeducation and socialising to the CBT model is likely to concord with improved outcome for some clients. Additionally, Renaud et al.'s (2014) factor analysis suggest that improved outcomes are more likely to relate to an individual's ability to engage in the wider psychotherapeutic process than their specific relationship with the CBT model.

It was hoped that this review would assist in the process of assessing people for suitability for CBT. This has been achieved to a limited degree as a number of factors such as interpersonal styles have a relatively robust evidence base. The difficulty comes with measuring these in a clinical context however. Whilst it may be possible to ask all patients about their expectations for therapy, or even administer Borkovec and Nau's (1974) Treatment Credibility Questionnaire, it is far more difficult and time consuming to administer the IIP-127 to individuals referred to a service. Similarly, despite the mixed evidence reported for individual factors, the validity of the SSCT indicates that it is both possible and advantageous to identify who CBT might and might not be suitable for before

commencing treatment. However, its time consuming interview structure raises the question of how cost efficient it is in practice. The ability to identify who CBT might be effective for remains important however, and, whilst therapist appraisal of the factors identified in this review remain vital, a simple tool to measure these at intake would be of great value.

Areas not covered in this review and recommendations for future research

A number of studies were identified during the course of this review that, whilst they add to the broader discussion of predictors in CBT, were not within its bounds. In particular a number of studies and reviews of group and internet CBT were identified and each of these modes of treatment would benefit from further review. Similarly studies of other disorders, (e.g. psychosis), of comorbidity and of specific demographic variables (i.e. different age groups) would also benefit from review. Finally a number of studies were identified that measured psychological predictors (or changes in predictors) over the full course of therapy (e.g. Ablon & Jones, 2002; Addis & Jacobson, 1996) rather than pre or early treatment. Whilst these did not fit the criteria for this review their findings are both insightful and thought provoking with regard to people's experience of and response to therapy.

This review has identified a number of gaps in the literature on pre-treatment psychological predictors of outcome in CBT. First the literature would benefit from greater consistency in measurement tools, particularly in the fields of expectancy/credibility and personality. Given that the search for predictors often involves investigation of large numbers of correlates it would also be beneficial to pay greater attention to the issue of power, either through larger sample sizes (although it is acknowledged this is not always possible) or through the measurement of fewer and more specific correlates. A small number of studies have explored the mediational relationship between multiple predictors and outcomes. Greater research into these relationships would shine a light on the particular nature of predictive relationships. Finally further development of simple to use tools to help assess the comparative suitability of CBT and other treatments for different individuals must be a priority, in

order to better streamline and improve the effectiveness of psychotherapy services. An investigation of such a tool is carried out in Chapter 3 of this thesis.

Chapter 3

Who does CBT work for? A validation of CBT-Suitability Scale (CBT-Suits)

Introduction

Cognitive Behaviour Therapy (CBT) has demonstrated its efficacy for the treatment of multiple disorders in a range of mental health settings (Roth & Fonagy, 2006) and is a primary treatment recommended in United Kingdom Improving Access to Psychological Therapies (IAPT) services for the treatment of anxiety and depressive disorders (National Collaborating Centre for Mental Health, 2021). However, one size does not fit all, and CBT does not have the same efficacy for everyone, with methods of determining which treatments are most suitable for a given individual being broadly limited to clinical judgement, presenting problem and assessment of symptom severity (Beck & Beck, who 1995; Westbrook et al., 2007). To facilitate this, mental health services commonly use psychometric symptom severity scales, with clinical cut offs as an integral part of assessment of suitability for treatment (National Collaborating Centre for Mental Health, 2021).

Improving Access to Psychological Therapy and the Stepped Care Model

This is particularly true of IAPT services, where the recommended treatment pathway is the stepped care model (National Collaborating Centre for Mental Health, 2021). Under the stepped care model patients are assessed using a range of symptom severity self-report measures, alongside clinical assessment interviews, and offered treatment on a sliding scale of intensity. Treatment often begins at Step 1, usually provided by non-mental health practitioners, with treatments such as unguided self-help and bibliotherapy. If this is unsuccessful patients may be referred (or self-refer) to an IAPT service, where they may be treated at Step 2, or "Low Intensity", provided by a Psychological Wellbeing Practitioner (PWP), who is trained in psychological interventions such as graded exposure or guided self-help. Where need is assessed as being greater a more intensive level of treatment may be offered by a Psychotherapist or Counsellor at Step 3. Individuals who present with risk, complexity, or symptom distress too severe for IAPT treatment are then referred onto Step 4 or secondary services where they may receive multi-disciplinary treatment.

The rationale for the stepped care model utilises symptom severity as a key indicator of the intensity of treatment that an individual needs, following the principle that many people with mild to moderate disorders are likely to benefit from a less intensive treatment at Step 2 without the need for more intensive "High Intensity" treatment at Step 3 unless they fail to recover (Richards, 2012). People suffering from more severe symptoms of depression, or from harder to treat disorders such as Social Anxiety (American Psychiatric Association, 2013) however, bypass the low intensity step and are treated by a high intensity psychotherapist or counsellor as a first treatment (National Collaborating Centre for Mental Health, 2021). This model has a lot of benefits in terms of cost to service and demonstrates positive treatment outcomes (Richards, 2012), It has also been shown to be equally effective in achieving clinical outcomes as the alternative matched care model, in which clinical assessment is weighted more heavily in decisions about which therapy modality an individual is offered (van Stratton et al., 2006).

Issues with the Stepped Care Model

However, therapy drop out and recovery rates suggest there is room for improvement in this selection process (NHS Digital, 2020) and not all IAPT services utilise the stepped care model in the same way (Richards et al., 2012). This can give rise to variations in practice with ratios of low intensity to high intensity treatments varying from 22:1 in favour of low intensity to 1:2 in favour of high intensity (Richards et al., 2012). Further the method of assigning patients to a level of care based predominantly on diagnosis and symptom severity has its limits, and many people find that a more intensive level of treatment is necessary in order to recover, with around 10% of patients entering Step 2 being stepped up to Step 3 (Richards et al., 2012). This can lead to increased client attrition, as transition points in care (such as referral to assessment or assessment to treatment) are particularly vulnerable to patient drop out. Indeed these numbers are quite high, in one longitudinal study of 7859 patients referred to a city IAPT service, 27% of patients were found to have left the service at any given transition point, resulting in only 53% of people initially referred to the service receiving two or more treatment sessions (Richards & Borglin, 2011). Further, recovery rates for IAPT services nationally in 2019/20 averaged 51.1% (NHS Digital, 2020), giving rise to the question, how many

people would have achieved a greater degree of remission had a more subtle method of screening for High and Low intensity of treatment been available?

Symptom severity is only one of many factors linked to outcomes in CBT however, at times being responsible for only 10% of variance in clinical outcomes (McLellan et al., 2019) making the selection of patients for high or low intensity intervention a difficult one. This could perhaps be improved if a method of incorporating alternative predictors of treatment efficacy into the stepped care decision making process could be found.

Predicators of outcome in CBT

The identification of pre-treatment predictors of treatment efficacy in psychotherapy has multiple benefits for patients, services and commissioning alike. If it is possible to ascertain who will respond best to a given level or modality of treatment it would enable services to provide the best treatment for any given individual at the most efficacious level in the most cost effective way.

However, research into the identification of such predictors has primarily focused on symptom severity and complexity. Factors such as pre-treatment symptom severity, chronicity, age of onset, and number of previous episodes have all been identified as indicators of reduced treatment efficacy (Hamilton & Dobson, 2002; Hundt et al., 2014; Kampman et al., 2008; Lorenzo-Luaces et al., 2020). Research into non symptom related indicators of treatment outcomes has however, identified far fewer predictors of outcome. CBT is effective for people of any age (Arnberg & Öst, 2014; Hundt et al., 2014; Kendall & Peterman, 2015), and for people from a range of demographic backgrounds and social conditions (Hamilton & Dobson, 2002; Hundt et al., 2014). There is significant evidence that in treatment behaviour, emotional involvement in therapy and therapeutic relationship can relate to outcomes (Castonguay et al., 1996), but as these are dependent on the behaviour of both therapist and client in the therapy session it is difficult to use these as pre-treatment predictors of change.

One area that has received a degree of attention (though perhaps not as much as clinically related factors) has been that of clients' non clinical psychological profiles and attitudes to therapy.

As has been discussed in greater detail in Chapter 1 of this thesis, a range of factors such as client interpersonal and attachment style (Hardy et al., 2001; McEvoy et al., 2014; Saatsi et al., 2007); belief in treatment and outcome expectancy and (Borkovec & Mathews, 1988); personality (Bagby et al., 2008; Mortberg & Andersson, 2014); reactivity to stress (Gunthert et al., 2005); and acceptance of responsibility for change (Safran et al., 1993) have been identified as potentially predicting outcomes in CBT. However, the effect of this knowledge on the design of service and treatment has been limited and does not impact on stepped care selection in a formal way.

CBT suitability screening measures

One method of potentially improving this decision making would be to introduce a valid, self-report measure of psychological and attitudinal suitability for CBT into assessment sessions. Whilst there have been a number of studies investigating which pre-treatment psychological factors might predict outcome in CBT, research into the development of screening tools to make practical use of this knowledge has been extremely limited.

One such tool, the Suitability for Short Term Cognitive Therapy Scale (SSCT) (Safran et al., 1993) has been shown to be effective in predicting patient suitability for CBT (Myhr et al., 2007; Renaud et al., 2014; Safran et al., 1993). However, the SSCT is a therapist assessed screening tool that takes the form of an hour long semi structured interview. As such it has limited utility in a busy NHS psychotherapy service due to the cost of implementation. This cost would be greatly reduced if the measure was in the form of a self-report questionnaire. There are two pre-treatment self-report scales which aim to predict outcomes in CBT, the Anxiety Change Expectancy Scale (ACES) (Dozois & Westra, 2005) and the Suitability for Cognitive Behaviour Therapy Scale (CBT-Suits) (McLellan et al., 2016). The ACES is a 20 questions pre-treatment questionnaire designed to be completed by patients suffering symptoms of Generalised Anxiety Disorder (GAD) (American Psychiatric Association, 2013). The scale, which focuses on responder's expectations and beliefs about the possibility of improvement in their worry, has been validated in a clinical sample of patients attending group CBT for Anxiety, and shows predictive validity with regards to improvements on symptom

severity measures for GAD. However, this measure is diagnosis specific, and its focus on worry makes it unlikely to be effective with a wider population. Therefore, the best candidate to date is the CBT-Suits (McLellan et al., 2016, McLellan et al., 2019), a brief, self-report questionnaire that has shown good initial factor structure and promising initial psychometric properties (McLellan et al., 2016).

The CBT Suitability Scale. The 13 question CBT-Suits Scale (McLellan et al., 2016) is a self-report scale designed to be administered to recipients of CBT pre therapy, which aims to assess an individual's suitability for CBT based on a number of attitudinal questions, distinct from symptom severity.

In the process of designing and testing the CBT- Suits, McLellan et al. (2016) included a series of initial constructs which might predict suitability for therapy from the pre-existing literature and expert discussion. These were:

1. "monitoring and developing awareness and expression of thoughts, feelings and responses";
2. "challenging and evaluating thoughts and beliefs";
3. "developing flexibility in thinking";
4. "experimenting and learning from behaviour and experiences"; and,
5. "an understanding of the important role of thinking in facilitating changes to behaviour, emotions, and other responses"

(McLellan et al., 2016, p. 689)

This initial development of the CBT-Suits has a good theoretical grounding, and these initial constructs relate strongly to the core principles and techniques of CBT. To explore them in order; construct one "monitoring and developing awareness and expression of thoughts, feelings and responses"; relates to insight into one's thoughts, emotions and behaviour; which is central to the core principles of CBT. Constructs two and three both relate to the ability to reflect on and re-evaluate our thoughts. Construct two, "challenging and evaluating thoughts and beliefs", could be seen as relating

to a specific and widely used therapeutic technique in CBT, known as cognitive restructuring (Beck et al., 1979) in which individuals are taught to bring to mind catastrophic thoughts about a given situation, and assess their truth or helpfulness against observed evidence. Construct three on the other hand "developing flexibility in thinking" can be seen as a more general principle that is important throughout the therapy process, as cognitive flexibility is required to challenge and revaluate thought processes. Construct four "experimenting and learning from behaviour and experiences", applies to the experiential component of CBT, in which participants are encouraged to engage in behavioural experiments (Bennett-Levy et al., 2004) to help them test out their beliefs through lived experience. McLellan et al.'s (2016) final construct, "an understanding of the important role of thinking in facilitating changes to behaviour, emotions, and other responses", is another general but important one, and relates to perhaps the core process in CBT. This is the presumption that cognitions, emotions and behaviour, are interconnected and that consequently, one can be affected by changes to another (Beck et al., 1979).

The CBT-Suits also compares well to existing literature. As discussed in depth in Chapter 1 of this thesis, no single nonclinical psychological factor has yet been found that unequivocally predicts outcomes in CBT. However, McLellan et al.'s (2016) predictors share a number of similarities with Safran et al.'s (1993) multi factor SSCT (discussed above), which McLellan et al. (2016) draw on in their study. In particular McLellan et al.'s (2016) first principle; "monitoring and developing awareness and expression of thoughts, feelings and responses", bears close resemblance to Safran et al.'s (1993) "awareness and differentiation of emotion" and "accessibility of automatic thoughts" (p.231); whilst principle five "an understanding of the important role of thinking in facilitating changes to behaviour, emotions, and other responses" is similar in some respects to Safran et al.'s (1990) "compatibility with the cognitive rationale" (p. 232). McLellan et al.'s (2016) second, third and fourth influencers, the ability to benefit from "challenging and evaluating thoughts and beliefs", "developing flexibility in thinking" and "experimenting and learning from behaviour and experiences" also bear some comparisons to the "compatibility with the cognitive rationale" but

appear to relate more strongly to the ability to practically engage in and learn from the CBT process as discussed above.

The development of the CBT-Suits scale

McLellan et al. (2016) developed an initial 45 item questionnaire to measure these constructs, which was administered to a sample of 261 undergraduate psychology students. Following an initial exploratory factorial analysis and after correcting for correlations with symptom severity, McLellan et al. (2016) constructed a twelve question CBT-Suits questionnaire that had a three factor solution. These factors were CBT Rationale, which investigates beliefs about the interdependence of thoughts, feelings and behaviours (e.g. Q1 If I change the way I think my emotions would be different); Insight which explores awareness of affect and cognitions (e.g. Q4 I am able to be really aware of how I am feeling); and Behaviour, which asks about how responders learn from and react to stressful situations (e.g. Q6 I go and face up to things that are difficult). A fourth factor, that of Physiology was removed after correlation with symptom severity was discovered. A thirteenth question (Q13 Even though trying new things is difficult for me, it means things change for the better) was added in a follow up factor analysis completed with a sample 397 members of the public, to add weight to the Behaviour factor. A second order factor, overall CBT-Suits Total, was also identified at this stage. A full version of the CBT-Suits is included in Appendix A. The CBT-Suits showed generally good internal consistency at this stage (Total, $\alpha = .76$; CBT Rationale, $\alpha = .75$; Insight, $\alpha = .79$); although the consistency of the Behaviour factor was lower, ($\alpha = .58$) (McLellan et al., 2016). McLellan et al. (2016) completed a final factor analysis with 235 members of the public recruited from adverts placed in settings likely to be frequented by people seeking mental health support, such as medical centres, mental health support groups and psychological service. Internal consistency remained in a similar range to that revealed in study two of the same paper ($.62 \leq \alpha \leq .80$), factor loadings for each of the four factors were significant ($p < .01$) and confirmatory factor analysis (CFA) indicated a good fit (CFI = .96, RMSEA = .05).

Whilst no study of the predictive qualities of the CBT Suits for individual CBT has yet been completed, McLellan et al.'s (2016) second study investigated collinearity with participants' beliefs about the credibility of CBT as a treatment. They found a strong correlation between the CBT-Suits and participants beliefs in the credibility of CBT, as measured by the Treatment Perceptions Questionnaire (Deacon & Abramowitz, 2005) for both the overall questionnaire and its factors. McLellan et al. (2016) rightly draw on studies by Devilly and Borkovec (2000); Fennell and Teasdale (1987) and Safran et al. (1997) to assert that treatment credibility can be a positive predictor of CBT outcomes. However, a wider review of studies of treatment credibility and its highly associated counterpart *attitudes about therapy*, as conducted in the literature review in Chapter 2 of this thesis, draws a more mixed picture, with only six of eighteen identified studies of credibility and optimism about treatment in one to one CBT finding a positive correlation with treatment outcomes.

The predictive validity of the CBT-Suits has only been tested on a single clinical sample to date. When used with a sample of 55 adults participating in a clinical trial investigating group CBT for social anxiety in Australia, it demonstrated good predictive qualities for outcomes over and above that predicted by initial symptom severity at the end of treatment, and at three month and six month follow up (McLellan et al., 2019). The CBT-Suits also explained 12-15% of the variances in symptom outcome measures, compared to clinician (10%) or patient (15%) reported initial severity measures, in the same study. This gives weight to the argument that if the measure were found to have predictive validity it could potentially be of use by IAPT CBT therapists to aid their clinical decision making, and consequently support the more effective use of resources. This would also be of significant benefit to people attending for therapy, enabling them to access the most appropriate treatment more easily.

Aims / Research Questions

The primary purpose of this study was to examine the predictive validity and factor structure of CBT-Suits in adults receiving short term individual CBT for anxiety and depressive disorders in an IAPT setting. However, due to difficulties in recruitment (discussed below), this was expanded to

include patients receiving counselling and Step 2 interventions. This amendment served two purposes. First in addition to increasing the pool of potential recruits to the study this enabled the study to cross test the predictive validity of the CBT Suits questionnaire across different interventions. This allowed us to better understand whether the CBT suits' predictive validity is specific to CBT or might be applied to other interventions (in this instance counselling and guided self-help based CBT interventions). Secondly this provided a larger sample with which to explore the factor structure of the measure. Given that this is a pre-treatment measure the factor structure should not be affected by the treatment that the participant goes on to receive.

In order to investigate the utility of the CBT-Suits in a clinical setting, five Research Questions were formulated:

a. Is the existing factor structure of the CBT-SUITS confirmed in a UK IAPT sample?

b. Does the CBT-SUITS show adequate internal consistency in this sample?

c. Does the CBT-SUITS predict the outcome of CBT for common mental health problems, over and above initial symptom severity, in a UK IAPT sample?

d. Is there any variation in the predictive validity of the three subscales of the CBT-SUITS in a UK IAPT setting?

e. Is there any variation in the predictive validity of the CBT-Suits over and above that of initial symptom severity measures when applied to participants receiving any treatment compared to those receiving 1:1 CBT only.

Method

Design

The study employed a pre-post design, with the CBT-SUITS being administered prior to the beginning of therapy, along with baseline outcome measures routinely collected in the service; and outcome measures being repeated at the end of therapy.

Participants

Participants were recruited from referees and self-referees to an English IAPT service. The service provides free to access CBT and Counselling for common depression and anxiety focused mental health disorders. Treatments are provided under the National Health Service (NHS) stepped care model (National Collaborating Centre for Mental Health, 2018) steps two and three, step one being provided by non-specialist medical providers. Step 2 treatments, for mild presentations of anxiety or depression consist of CBT based guided self-help and psychoeducation, delivered by Psychological Wellbeing Practitioners (PWPs) who have received training to Post Graduate Certificate level. Step 3 treatments, for moderate to severe depressive and anxiety disorders, consist of CBT psychotherapy provided by Cognitive Behavioural Psychotherapists, who have received training to at least Post Graduate Diploma level in CBT, or trainees on such a programme; and qualified Counsellors. Whilst treatments are delivered in group and individual settings, participants were drawn from people who had been accepted for individual therapy. Referral criteria for the study were adults over 18 years of age suffering from mild to severe anxiety or depressive disorders, without psychotic or personality disorders (unless these were in remission or well controlled), or significant substance misuse difficulties. English language skills necessary to complete the questionnaire were also required.

147 people completed the CBT-Suits questionnaire, though this was reduced for analysis due to missing data (see results section). As can be seen in Table 1, ages of participants ranged from 18 years to 94 years. 94 of the participants identified as female and 37 as male; no other genders were identified by participants. The majority of participants identified as white with the rest of the sample identifying as mixed ethnicity, black, or another ethnicity (not identified)). 118 participants entered the study with initial symptom severity scores in the clinical "caseness" range (either PHQ-9≥9 or GAD-7≥7) (National Collaborating Centre for Mental Health, 2021), indicating that they were experiencing symptoms meeting the criteria for treatment in the participating service. Treatment was sometimes offered to clients with initial symptom severity scores lower than caseness where other with the symptom severity measures. 65 participants presented with an anxiety disorder of whom 49

participated in the primary predictive validation. Of these the most common disorder was Generalised Anxiety Disorder (GAD). 50 participants presented with either a depressive episode or recurrent depressive disorder of whom 33 participated in the primary predictive validation. Two participants were identified as presenting with an eating disorder, one of whom went on to CBT treatment. No primary presenting problem was identified for seventeen of the participants of the CFA though none of these went on to treatment. Individuals screened as suitable for one to one Step 3 CBT or counselling were offered a range of pre-treatments. These included one or two socialisation to CBT sessions, computerised CBT treatments or one off introductory workshops.

Table 1

Demographic information for Suits11 data.

	CFA	Predictive Validity (CBT Only)	Predictive Validity (all treatments)
n	131	83	99
Gender			
Female	94	57	71
Male	37	26	28
Not Stated	1		
Age	18-94 (M=37, SD=16.485	18-94 (M=37, SD=17.444)	18-94 (M=37, SD=16.732)
Ethnicity			
Black	1	1	1
Mixed	4	1	2
Other	1	1	1
Unknown	4	3	3
White	121	77	92
Assessment PHQ-9 and GAD-7 Scores			
PHQ-9	M=16.517, SD=5.318	M=16.10, SD=5.176	M=16.450, SD=5.321
GAD-7	M=14.283, SD=4.380	M=14.33, SD=4.168	M=14.310, SD=4.237
Participants Meeting Caseness* on PHQ-9 and GAD-7 at assessment			
PHQ-9	111	76	91
GAD-7	114	80	102
PHQ-9 & GAD-7	89	75	88
Presenting Problem			
Agoraphobia	1	1	1
Depressive Episode	37	24	34
Eating Disorder	2	1	1
Generalized Anxiety Disorder	39	27	31
Health Anxiety	1	1	1

Obsessive-Compulsive Disorder	4	4	4
Panic Disorder	6	6	6
Post-traumatic Stress Disorder	3	1	2
Recurrent Depressive Disorder	12	9	10
Social Phobia	8	8	8
Specific (isolated) Phobias	1	1	1
Unknown	17	0	0
Employment and Benefits			
Employed Full Time	48	35	40
Employed Part Time	23	15	20
Employed Hours Not Known	1		1
Full Time Homemaker/Carer	1	1	1
Long Term Sick/Disability	5	2	4
Retired	10	9	9
Student	12	9	10
Unemployed	17	12	14
Unknown	15		
On Benefits	10	4	7
Other variables			
LTC	41	27	33
History of Therapy	95	57	73
Pre Treatment sessions	27	20	24

*Caseness = PHQ-9≥9, GAD-7≥7, **Recovery = PHQ-9<9 and GAD-7<7

LTC=Pre-existing long term physical health condition; History of therapy= Participant indicated that they had received one or more courses of talking therapy prior to participation in the study; Pre-treatment sessions=patient engaged in one or more treatments prior to the core treatment during the study.

Measures

CBT- Suits

The CBT-Suits is a pre-treatment suitability for CBT scale comprising of three sub scales; Rationale, Insight and Behaviour. In addition to the original 13 question variant of the CBT Suits

(Suits13) described in the introduction to this study, an eleven question variant of the CBT-Suits (Suits11) was developed by McLellan et al. (2021) after factor analysis showed improved construct validity after the removal of questions six (I go and face up to things that are difficult) and ten (I can change what I do in a situation by changing the way I think about it). This version of the questionnaire has not yet been published, and was provided by its lead author (L. McLellan, personal communication, October 20, 2021). It was developed after data collection but before analysis of the current study and thus did not influence data collection of this study. The Suits11 was not found to significantly predict symptom severity outcomes in McLellan et al.'s (2021) study of a large sample of 1,132 attendees for internet based CBT for depression and/or anxiety in an Australian health clinic. However, McLellan et al. (2021) did find that changes in Suits11 scores before and after treatment were predictive of changes in symptom severity measures.

Symptom severity measures

Symptom Outcome measures given as part of common treatment protocols were also accessed. UK IAPT services utilise two primary self-report measures of depression and anxiety to assess patient recovery known as the minimum data set (MDS), the Patient Health Questionnaire 9 (PHQ-9), (Kroenke & Spitzer, 2002), a measure of depression and the General Anxiety Disorder 7 (GAD-7) (Spitzer et al., 2006), a measure of general anxiety.

The PHQ-9. The PHQ-9 (Kroenke & Spitzer, 2002) is a nine question frequency based symptom severity self-report scale for depression. The questions are derived from the DSM 5 diagnostic criteria for Major Depressive Disorder (American Psychiatric Association, 2013). Responders are asked to rate the frequency of their depressive symptoms on a Likert type scale from zero to three, where zero represents no experiences of the symptom and three represents experiencing the symptom "nearly every day". Cut offs for the PHQ-9 are 0-4, sub clinical symptoms; 5-9, mild depressive symptoms, 10–14 moderate depressive symptoms, 15–19 moderate to severe depressive symptoms, and 20–27 severe depressive symptoms (Kroenke & Spitzer, 2002). In IAPT service a score of nine or higher usually indicates suitability for treatment (National Collaborating Centre for Mental Health, 2021),

and is designated “caseness”. The PHQ-9 shows good construct validity and reliability for the general population (Martin et al., 2006) and is a frequently used depression severity questionnaire in the NHS (National Collaborating Centre for Mental Health, 2021)

The GAD-7. Constructed in a very similar style to the PHQ-9, the GAD-7 (Spitzer et al., 2006), is a seven question measure of Generalised Anxiety Disorder (American Psychiatric Association, 2013). The GAD-7 utilises the same four level Likert type scale of symptom frequency as the PHQ-9. Cut offs for the GAD-7 are 0-4 sub clinical symptoms, 5-9 mild anxiety, 10-14 moderate anxiety, and 15 - 21 severe anxiety (Spitzer et al., 2006). The minimum caseness, or suitability for treatment score in IAPT services for the GAD-7 is seven (National Collaborating Centre for Mental Health, 2021). Like the PHQ-9, the GAD-7 shows good construct validity and reliability for the general population (Lowe et al., 2008) and is a frequently used depression severity questionnaire in the NHS (National Collaborating Centre for Mental Health, 2021).

Identification of Core Treatment

The participating service offers four core treatments: Step 3 CBT, Counselling, Eye Movement Desensitization and Reprocessing (EMDR), and Step 2 Guided Self Help. Given that the core focus of the CBT-Suits is to identify pre-treatment suitability for CBT, this was identified as the core treatment where it occurred at Step 3 (full therapy) level. Where Step 3 CBT was not offered, the core treatment was identified as the final treatment that the client had in that treatment (referral) episode. This was because the service follows a stepped care/matched care structure (van Stratton et al., 2006). This means that in some cases attendees are matched to the most appropriate therapy for them at assessment, however in others an individual might be offered a lower intensity Step 2 treatment and the be “stepped up” to a more suitable step 3 treatment if this is not effective. In these circumstances it was decided that the core treatment would be the more intensive one. Where a participant engaged in Step 2 treatment before “step up” this was recorded in the “pre-treatment” data collection.

Identification of receipt of talking therapies prior to starting the study

In addition to the CBT-Suits, participants were asked whether they had received talking therapy prior to starting the study and given multiple choice options to identify what that therapy was.

Procedure

Approvals and consent

The study was approved by the NHS Research Ethics Council, the Health Records Authority, the participating Trust's Research and Development department and the sponsoring university. All participants were offered information about the study before agreeing to sign a consent form detailing their rights. Information and Consent forms are provided in full in Appendices B and C.

Data collection

First stage of recruitment. Initial data collection took two forms. First, all referees into the service were offered an initial screening assessment by telephone or face to face. During this assessment, service users were asked if they would like to be contacted further about ongoing research in the department, responses to this question were recorded in the service user clinical record. Service users who respond in the positive and who had been screened as suitable for Step 3 CBT were contacted by email offering another opportunity to participate in the study via the online questionnaire.

On attending their first appointment with a Step 3 CBT therapist, potential participants were asked if they had completed the online questionnaire or brought a pre completed questionnaire and consent form. If they had not, they were asked if they had been sent the information sheet and whether they had any questions. They were then offered another opportunity to read the information sheet and asked if they wish to participate in the study. If assenting they were asked to complete the CBT-Suits and Consent forms. In addition to the CBT-Suits, participants were asked about their previous experience of therapy and for permission to access their clinical records, to obtain demographic and routinely collected outcome data. Paper consent and questionnaire forms were put in envelopes marked "Questionnaire and Consent" without being read by the therapist receiving them.

Second stage of recruitment. Unfortunately, there were some difficulties in recruitment. There were two prime reasons for this. First it was more difficult than anticipated to engage therapists in the study, secondly due to the restrictions during the Covid-19 pandemic, the service moved to a primarily video conferencing and telephone model of therapy delivery. As a result a third participant recruitment method was added. This took the form of a modification to initial routine texts to service entrants to include brief information on the study and a link to further information. After accessing the further information respondents were offered the opportunity to participate in the study via a secure online survey tool. At this stage recruitment was expanded to include all entrants to the service, including those who received step 2, counselling, or no ongoing treatment, as discussed in the Aims section above.

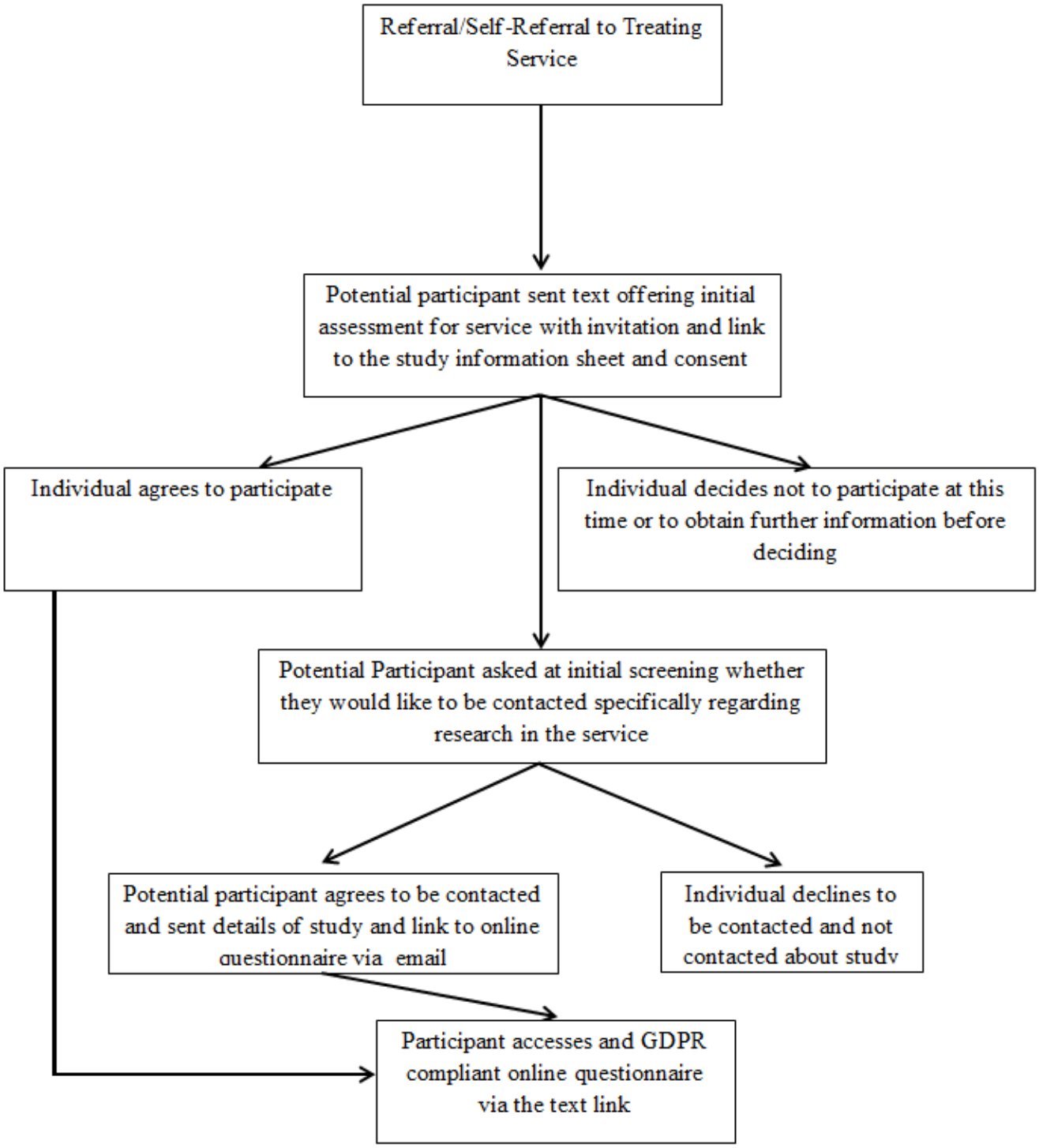
Data collection timeline and flowchart. Data were collected at three points in the study owing to the need to change the recruitment process. The specific timeline for collection is shown in Table 2. A flowchart for online recruitment is contained in Figure 1.

Table 2
Data collection times

Data collected	Data point 1	Data point2	Data Point 3
CBT Suits (Paper)		Start of Core treatment	
CBT Suits Online)	Entry to Service		
MDS	Entry to Service	Start of Core treatment	End of Core Treatment
Benefit use	Entry to Service		
Employment	Entry to Service		
Ethnicity	Entry to Service		
Age	Entry to Service (18 & over only applicable)		
Gender	Entry to Service		
Reliable Change			End of core Treatment
Recovery			End of core Treatment
Non Core Treatments in Episode			End of core Treatment
Previous Treatments	Entry to Service		

Figure. 1

Online recruitment flowchart



Process for identifying and storing personal participant data. Paper participant consent forms, which contained identifiable data by necessity, were linked by an anonymous study ID number to questionnaires, ensuring that no identifiable participant data were held on completed

questionnaires. Consent forms holding identifiable data and study ID numbers were held by the chief investigator securely and separate from the study data. Where a participant opted to complete online questionnaires, their data were held in a secure server until retrieval.

Ethical Considerations

Ethics of pre-treatment predictors of therapy scales

The development of tools designed to predict outcomes in CBT is an area that brings with it a particular set of ethical considerations. Outcome reduction is not the only measure of success in therapy, yet services such as IAPT are measured on these as a key target (National Collaborating Centre for Mental Health, 2021). Coupled with service costs and budget considerations (as discussed in the introduction to this thesis), there is a danger of a perverse incentive to negatively gate keep (Pellegrino, 1986) services so as to exclude those in greatest need, who may take longer (and therefore cost more) to treat and be less likely to achieve recovery outcomes on approved measures. In order to counteract this de facto conflict of interest in services it is important to provide guidance and training on the use of a measure such as the one being tested, should it demonstrate evidence for practical usage, to ensure that it is used alongside clinical judgement and other measures to help consider what additional support that somebody might require in order to benefit from therapy, rather than exclude them from it. This issue is discussed at greater length in the general discussion at the end of this thesis.

Data collection

Data collection was undertaken by therapists and clinicians working for the participating service as part of the routine assessments or through an online questionnaire and did not require any risks on the part of these individuals other than those normally associated with seeing a new referral for the first time. The questionnaires that participants were asked to complete were similar to those that would routinely be asked in therapy and were not expected to present a risk to participants. Potential participants were informed that neither their decision about whether or not to participate, nor their answers to the questions, would affect their treatment in any way. A signed copy of the consent

form and the information sheet was offered to participants. Only members of staff employed by the participating service, e.g. administrators and therapists, had access to patient records prior to consent. Following consent and agreement to participate in the study researchers had access to information gathered by the service that was relevant to the study. All Study activities were carried out by employees of the participating NHS Trust or, in the case of supervision of the chief investigators PhD, by employees of the sponsoring University. Only employees of the participating NHS Trust had access to participant identifiable data.

Data analysis

A confirmatory factor analysis was undertaken on both the Suits11 and the Suits13 data, to determine whether the existing three-factor structure (McLellan et al., 2016; McLellan et al., 2021) was valid for a UK IAPT population. Three goodness of fit measures, the minimum discrepancy (X^2), the Comparative Fit Index (CFI) (Bentler,1990; in Byrne, 2013) and the Root Mean Square Error of Approximation (RMSEA) (Steiger & Lind, 1980, in Byrne, 2013) were utilised, in order to explore the goodness of fit from a number of perspectives as recommended by Byrne (2013). Cronbach's alpha was then calculated for both questionnaires, to determine whether the overall score and three factors have sufficient internal consistency in this population. Linear assumptions were tested prior to regression analysis. Correlations between the CBT-Suits and symptom severity scores on the PHQ-9 and GAD-7 at assessment and discharge were then calculated. The CBT-Suits was then tested for predictive validity for post treatment PHQ-9 and GAD-7 over and above that provided by assessment PHQ-9 and GAD-7 scores, for participants attending CBT treatment. Baseline symptom severity was controlled for by conducting separate two step hierarchical regressions for the PHQ-9 and GAD-7 measures, in which the primary step included the predictor assessment PHQ-9 or GAD-7 score and the second step was the addition of the predictor CBT-suits total score. As a follow up analysis, the primary tests of predictive validity were repeated, replacing the CBT-Suits total score with the three first level factors of the CBT-SUITS (rationale, insight and behaviour) as predictors. The test of predictive validity was then repeated for all participants receiving treatment (including counselling

and Step 2), to check whether the predictive validity of the CBT-Suits varied between this and the CBT only group.

Results

Effectiveness of therapy

As a preliminary check, the outcome data were examined to determine whether the therapy offered by the service was, on average, associated with improvement (since if it was not, there would be nothing for the CBT-Suits to predict). As can be seen in Table 3, mean PHQ-9 and GAD-7 scores reduced over the course of the study, indicating that treatment was associated with lower discharge PHQ-9 and GAD-7 scores (CBT treatment group, PHQ-9 $t(82)=12.964$, $p<.001$, GAD-7 $t(82)=11.382$, $p<.001$; Whole treatment group, PHQ-9 $t(100)=14.077$, $p<.001$, GAD-7 $t(100)=12.682$, $p<.001$). The proportion of participants in "recovery" at the end of treatment, that is with both PHQ-9 and GAD-7 scores below the "caseness range" was 49% for both treatment groups, just below the 50% target for IAPT services (National Collaborating Centre for Mental Health, 2021). However, this target is for both Step 2 and Step 3 treatments, the former of which are likely to achieve much higher recovery rates due to lower initial symptom severity. As such the recovery rate of 49% is broadly in line with that expected for step 3 treatments in the participating service.

Table 3
CBT-Suits and Outcome scores

	CBT Only Mean (SD)	All Treatments Mean (SD)
	PHQ-9	
Pre Treatment	16.08 (5.183)	16.38 (5.320)
Post Treatment	8.22 (5.984)	8.25 (6.040)
	GAD-7	
Pre Treatment	14.31 (4.158)	14.23 (4.211)
Post Treatment	7.11 (5.257)	7.09 (5.307)
Number of Sessions of Core Treatment	5.69 (2.203)	5.67 (2.227)
	n (%)	n (%)
Participants in recovery at end of treatment*	41 (49.398%)	49 (49.000%)

*Recovery = PHQ-9<9 and GAD-7<7

Missing Data

For the Confirmatory Factor Analysis 16 participants were removed due to incomplete data leaving a total of 131 participants. 40 of the original 147 participants did not complete treatment and were removed from the predictive validity test leaving a total of 100, 89 of whom received CBT and 11 another therapy (Counselling or Guided Self Help). Of these, participant scores were removed if missing data were considered relevant to the factor being investigated. For instance, if a CBT-suits questionnaire was missing a response for question 1 it was removed from regression analysis for Total Suits scores and for regression of the Rationale Factor (made up of questions one, two, seven and eight). It was included for regressions of the insight and behaviour factors however as the missing data did not relate to these factors' treatment.

Confirmatory factor analysis

Theoretical model

Recall that the original CBT-Suits factor structure was a thirteen item questionnaire divided into three subscales, Rationale, Insight and Behaviour (McLellan et al., 2016), but that a more parsimonious eleven question version was recently developed in an, as yet unpublished study, with improved factor loadings (McLellan et al., 2021). In the current study the primary factor analysis was completed on the Suits11 due to its stronger factor structure (McLellan et al., 2021) however, a secondary analysis was conducted on the CBT-Suits13 (McLellan et al., 2016), due to the non-published status of the Suits11 at the time of writing. A second order confirmatory factor analysis (CFA) was conducted using the SPSS AMOS programme, following the procedure and model described in McLellan et al.'s (2016) second factor analysis for the Suits13 and McLellan et al.'s (2021) factor analysis for the Suits11, both of which in followed the procedure laid out by Byrne (2013). The path structure with factor loadings for the Suits11 and Suits13 are presented in Figure 2 and Figure 3 (below).

The decision to include correlation between certain errors as detailed in figures 2 and 3 followed the reasoning provided for inclusion in McLellan et al.'s (2016) original factor analysis. McLellan et al. drew on Cole et al.'s (2007) argument that correlations between error items were permitted due to the similar wording or format between questions within a given factor, as was the case between questions one and two, three and five, and seven and ten of the CBT Suits. As our intension was to confirm whether the specific factor structure proposed by McLellan, et al. (2016) was valid within the current study and given their original decision was justifiable, it was decided to include error correlations in the current analysis where the McLellan et al. (2016) had done.

Figure. 2

CBT-Suits11 path diagram

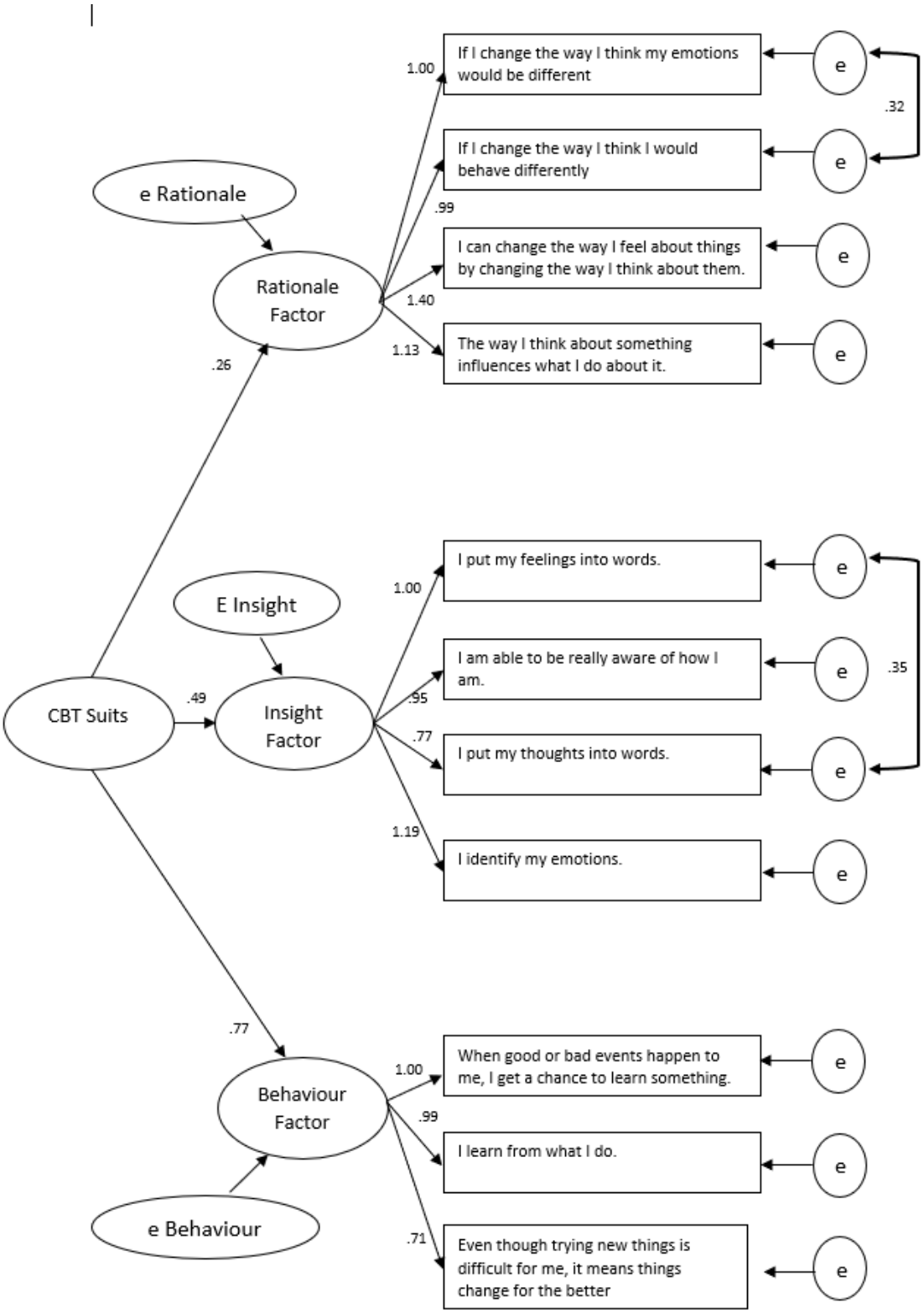
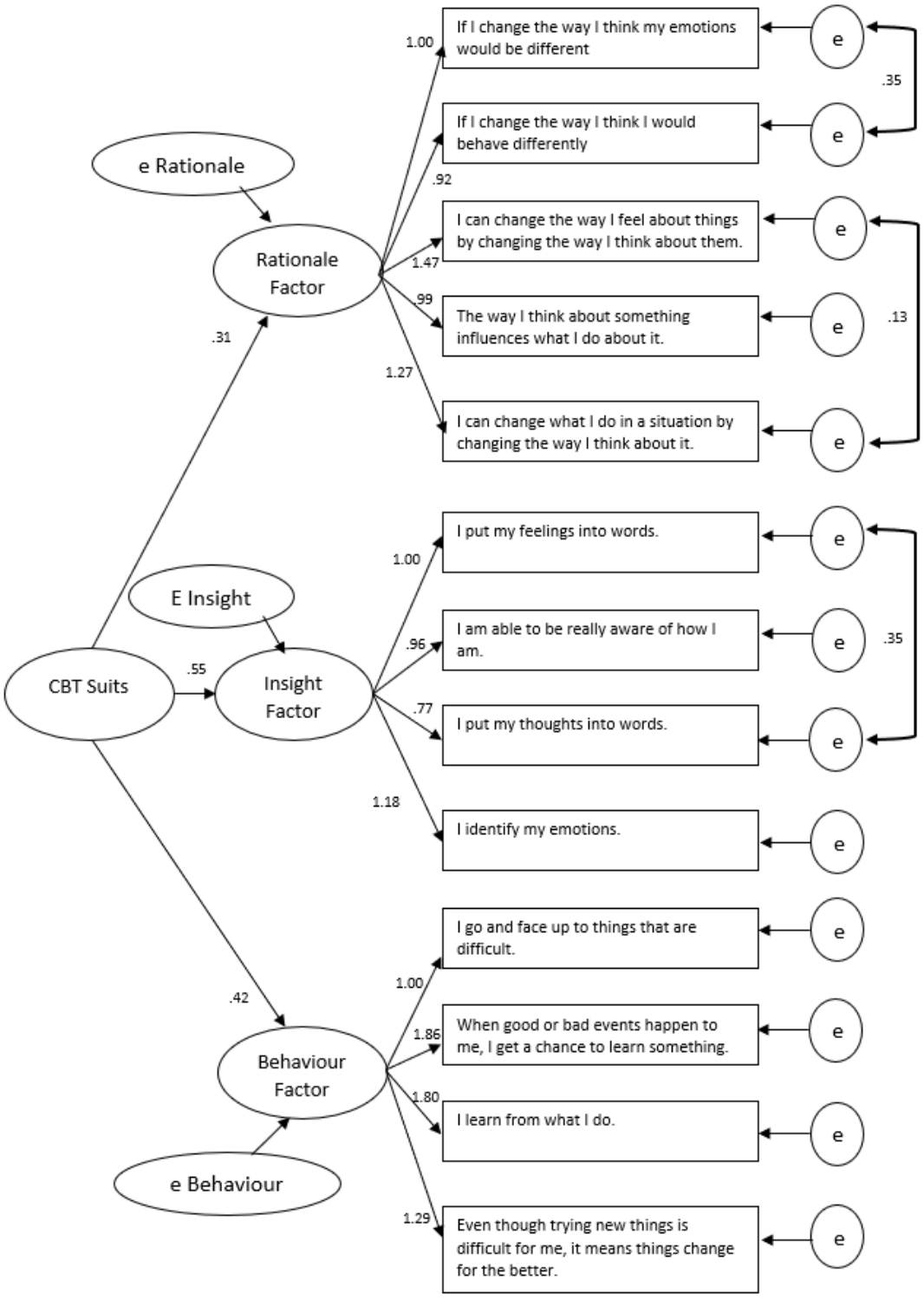


Figure. 3

CBT-Suits13 path diagram



The Suits11 and Suits13 demonstrated different factor loadings for the level one factors (Rationale, Insight and Behaviour). For the Suits11 Behaviour demonstrated the highest loading (.77), followed by Insight (.42) and then Rationale (.26), suggesting that of the three factors, Behaviour was influenced the most by the second order factor, Total Suits score. However, for the Suits13 the factor loadings were more evenly spread, with Insight being the highest (.46) followed by Behaviour (.42) and Rationale (.31).

Model fit. As recommended by Byrne (2013), a range of goodness of fit measures were utilised. These can be broadly categorised into *absolute* indices, which give a direct measure of how the data fit with the model presented; *parsimony* based indices, which account for model complexity by reporting based on degrees of freedom of the model; and *comparative* indices, which compare the model fit to a baseline model, the most common of which is the null, or independence model (Boetang, 2020; Byrne, 2013).

Absolute indices. One of the most commonly utilised absolute measures is the minimum discrepancy (Byrne, 2013), which employs the X^2 distribution to examine whether the observed covariances significantly differ from those that would be expected on the basis of the factor structure being tested. Whilst giving an indication of the fit of a model to the implied population covariance matrix, the X^2 and its associated likelihood ratio test are highly dependent on sample size. X^2 was not significant for the Suits11 ($X^2(40,n=131)=51.249$, $p=.110$) but was for the Suits13 ($X^2(60,n=131)=113.664$, $p<.001$) indicating that the proposed model for the Suits11 does not significantly differ from the data, and therefore has a good model fit. The model for the Suits13 however significantly differed from the data indicating that its fit is less good.

Comparative Indices. Of the range of comparative indices available the Comparative Fit Index (CFI) (Bentler, 1990; as cited in Byrne, 2013) was utilised because of its commonality of use and its ability to take sample size into account (Byrne, 2013). The CFI for the Suits11 was .973, compared with the null model, above both the >.90 cut off suggested by Bentler (1992, as cited in Byrne, 2013), as representing a good fit, and the revised >.95 cut off suggested by Hu and Bentler

(1999, as cited in Byrne, 2013). CFI for the Suits13 however was .896, just .004 below the >.90 cut off, demonstrating a reasonably good fit.

Parsimony indices. Root Mean Square Error of Approximation (RMSEA) (Steiger & Lind, 1980, as cited in Byrne, 2013) is of particular value in that it is possible to express confidence intervals around its values, enabling the accuracy of fit to the population to be estimated. RMSEA for the Suits11 was .047, below Brown and Cudeck's (1993, as cited in Byrne, 2013) <.050 cut off for a good fit between the hypothesised model and the data. The recommended 90% confidence intervals for the Suits11 data were .000 and .081 indicating that even at the upper limit the model was close to Brown and Cudeck's (1993) <.080 cut off for a reasonable fit. The RMSEA of .083, with 90% confidence intervals of between .059 and .106, for the Suits13 mirrored the pattern shown in the previous two indices, indicating a less good fit than that for the Suits11, and marginally outside Brown and Cudeck's (1993) reasonable fit cut off of <.080.

Fit summary. As can be seen in Table 4, the three goodness of fit measures all demonstrated similar findings. Whilst the Suits13 displayed a reasonably good fit on the CFI and RMSEA, it's fit indices were not as good as those on the suits11, and it was also less parsimonious (DF (Suits13)=60; DF (Suits11)=40) than the Suits11 (see Table 4), giving weight to McLellan et al.'s (2021) findings. Because of this the Suits11 was used as the primary measure in the regression analyses that follow.

Table 4
CBT-Suits Model Fit

Model	df	X^2	CFI	RMSEA
CBT-Suits11	40	51.249	.973	.047
CBT-Suits13	60	113.664***	.896	.083

***p<.001

Internal Consistency

Both the Suits11 and the Suits13 showed good internal consistency for both total scores and subscales. As can be seen in Table 5, Cronbach's alpha for the Suits11 was α=.785 indicating good internal consistency (Field, 2013). This was not significantly affected by the removal of any

individual items, with alpha remaining greater than α>.750 in all instances. Internal consistency for the Suits13 was slightly better than that for the Suits11 with Cronbach's alpha being α=.816 and remaining above α>.791 after the removal of any individual item. The slight difference between the 13 and 11 items version is likely due to the sensitivity of alpha to questionnaire size, rather than a reflection of better internal consistency of the 13item version (Cronbach, 1951).

Table 5
Internal consistency of the CBT-Suits including subscales

	Cronbach's α	
	Suits11	Suits13
Total	.785	.816
Rationale	.713	.747
Insight	.776	.776
Behaviour	.771	.686

Correlations

As an initial exploration prior to testing for predictive validity of the CBT-Suits, correlations between the Suits11 and the outcome variables were examined (see Table 6).

Table. 6

Pearson's r correlations between Suits Factors and PHQ9/GAD7 at assessment and discharge (n=131)

	PHQ-9 Assessment	GAD-7 Assessment	PHQ-9 Discharge	GAD-7 Discharge
Suits11_Total	-.304**	-.071	-.138	-.035
Suits11_Rationale	-.089	-.023	-.008	.070
Suits11_Insight	-.275*	-.004	-.122	-.074
Suits11_Behaviour	-.324**	-.234*	-.205	-.198

*p<.05, **p<.01

These demonstrated significant negative correlations between Suits11 Total scores and PHQ-9 Assessment scores; between Suits11 Insight and PHQ-9 Assessment; and between Suits11 Behaviour and PHQ-9 Assessment and GAD-7 Assessment. Of particular note, were the relationships

between PHQ-9 Assessment scores and Suits11 Total and Behaviour scores, which indicated a moderate effect size of r>.30 (Cohen, 1992), although the relationship with Suits11 Insight was only marginally below this cut off. This indicates that Suits11 scores are associated with participants' levels of depression at the time they completed the measure, with those with higher levels of depression tending to have significantly lower suits scores on its insight and behaviour subscales measures.

Tests of linearity and normality

Linearity of data were tested using the method suggested by Field (2013). Q-Q plots indicated only minor deviations from a normal distribution. Therefore, it was decided that transformation was not required before conducting regression analysis.

Tests of Predictive Validity.

Hierarchical regression analysis was employed to explore whether the CBT-Suits offered any predictive validity for outcomes, over and above that provided by symptom severity at assessment. The primary regression analysis examined data for participants receiving CBT (n=83) to determine whether the Suits11 had any predictive value over and above baseline PHQ-9 score. These were examined by including baseline PHQ-9 scores in the first step of a multiple hierarchical regression with post-intervention PHQ-9 scores as the dependent variable and adding Suits11 total scores as an additional predictor in the second step.

Unsurprisingly, higher PHQ-9 at assessment significantly predicted higher PHQ-9 at discharge ($F(1,81)=21.118$, $p<.001$; Beta=.455; $t(82)=4.603$, $p<.001$). However, the addition of the Suits11 total as a predictor in the second stage of the regression did not significantly improve the model fit ($\Delta F(1,80)=.000$, $p=.999$; Beta= .000; $t(82)= -.001$, $p=.999$). This analysis was then repeated but with GAD-7 assessment and discharge scores substituted for the respective PHQ-9 ones. The same findings were observed, namely that GAD-7 at assessment significantly predicted GAD-7 at discharge ($F(1,81)=4.431$, $p=.039$; Beta=.227; $t(82)=2.101$, $p=.039$), but that the addition of the Suits11 total as a predictor did not explain any more variability in the GAD-7 discharge data ($\Delta F(1,80)=.030$, $p=.864$; Beta=-.019; $t(82)=-.172$, $p=.864$). A secondary analysis was conducted

utilising the Suits13 Total, and once again the Suits score did not improve the predictions of the model for either PHQ-9 or GAD-7 (PHQ-9: $\Delta F(1,79)=.113$, p=.737; Beta=-.36; t(84)=-.337, p=.737; GAD-7: $\Delta F(1,80)=0.247$, p=0.621; Beta=0.071; t(84)=-0.497, p=.620). In summary, the CBT-Suits offered no additional predictive value to that provided by initial symptom severity scores.

Secondary analyses

In follow up analysis, individual subscales (Rationale, Insight and Behaviour) did not significantly predict PHQ-9 or GAD-7 discharge scores over and above that provided by assessment scores, for either Suits11 or the Suits13 (see Table 7 below).

Table 7
Predictive validity of CBT-Suits totals and subscales over and above initial symptom severity *(ΔF)*

	Suits11		Suits13	
	PHQ-9	GAD-7	PHQ-9	GAD-7
CBT-Suits Total	.000	.030	.113	.247
Rationale	.112	.507	.074	.014
Insight	.001	.461	.001	.461
Behaviour	.001	2.140	.382	1.587

*P<.05

A further regression was also conducted to ascertain whether the Suits11 was predictive of number of sessions of CBT attended, in order to identify any possible relationship with dropout rates. No significant relationship was found (F(1,81)=.014, p=.906).

Analyses including other treatment modalities

Additional analyses were conducted to explore whether the Suits11 data varied between the CFA only, CBT treatment and all treatment groups. As can be seen from Table 8, all groups gave similar responses to the Suits11 questionnaire, with means and standard deviations being very similar for all groups.

Table 8
Comparison of Suits11 scores between treatment and non-treatment groups

CBT-Suits11 scores	CFA	Predictive Validity (CBT Only)	Predictive Validity (all treatments)
Total	M=38.121, SD=6.695	M=39.000, SD=6.853	M=38.050, SD=6.774
Rationale	M=14.960, SD=3.120	M=14.908, SD=3.230	M=14.808, SD=3.178
Insight	M=12.667, SD=3.681	M=12.812, SD=3.571	M=12.578, SD=3.676

Behaviour	M=10.495, SD=2.443	M=10.393, SD=2.695	M=10.330, SD=2.628

A further analysis was conducted to investigate any predictive validity of the Suits11 for the whole treatment group (participants entering non-CBT treatments in addition to those entering CBT). This produced results similar to the results for the primary analysis for the CBT only group, as the Suits 11 showed no significant predictive validity beyond that provided by initial symptom severity scores (PHQ-9; $\Delta F=1.222$, p.>.05; GAD-7; $\Delta F=2.01$, p=.980).

Bivariate relationships between study variables

Bivariate correlation was used conducted on demographic statistics, number of sessions and history of therapy to determine whether they correlated with either Suits score or PHQ-9 or GAD-7 scores (Table 8). As can be seen in Table 9, no significant correlations were found.

Table 9

Bivariate relationships between study variables (r) (n=99)

	Age	Gender	Benefits	Employed	LTC	History of Therapy	No of Sessions
Suits11 Total	-.037	.036	.022	-.011	.070	.061	.013
Suits11 Rationale	-.106	.012	.013	.006	-.130	-.050	.073
Suits11 Insight	.057	.085	.040	-.045	.218	.158	-.083
Suits11 Behaviour	-.131	.102	.048	.036	-.053	.049	-.133
PHQ9 Assessment	-.076	-.161	-.023	.097	-.107	.050	.037
GAD7 Assessment	-.157	-.194	-.066	-.058	-.170	.008	.101
PHQ9 Discharge	-.141	.205	.027	-.076	.000	-.146	.067
GAD Discharge	-.010	.096	-.041	-.176	.001	-.092	.102

*p<.05; Benefits= in receipt of state benefits; Employed=in part or full time employment; LTC=Pre-existing long term physical health condition; History of therapy= Participant indicated that they had received one or more courses of talking therapy prior to participation in the study.

Discussion

This Study had two core purposes: first to test the internal consistency and confirm the factor structure of the CBT-Suits, as reported in McLellan et al. (2016) and McLellan et al. (2021), within a UK IAPT sample; and second, to test the predictive validity of the CBT-Suits when applied to individuals with common anxiety and depressive symptoms receiving CBT in a UK IAPT service.

The factor structure of the Suits11 was confirmed across a range of indices. This improved on the factor model fit of the Suits13 and concurred with McLellan et al.'s (2021) findings that the Suits11 is both the most parsimonious and demonstrates the best model fit for the CBT-Suits. Both the Suits11 and Suits13, and their subscales (Insight, Rationale and Behaviour) also demonstrated good internal consistency (the exception being the Suits13 Behaviour subscale).

There was no evidence that the total CBT Suits score or any of its three subscales offered any predictive validity for symptom severity outcome measures over and above that provided by initial symptom severity scores. It is possible that a larger sample size in the primary test of predictive validity may have identified a small effect but given the small size of the correlation coefficients associated with the regression this seems unlikely and, if one were to be found, it would be unlikely to provide an effect size large enough to be of use in a clinical setting (Field, 2013). These results seem to show a similar pattern to results from McLellan et al.'s (2021) study, which also found no evidence of predictive validity. This study is of particular import because of its large sample size, suggesting that, had a larger sample been possible in the current study it would be unlikely to provide different findings. They are however, different to the initial predictive validity data provided by McLellan et al. (2019), which found the CBT-Suits to be predictive of 7-15% of variance in outcomes.

One possible explanation for the difference in results between the current study and that conducted by McLellan at al. (2019) is the study population. Whilst it is difficult to directly compare symptom severity between the studies, due to their use of different measures, the majority of participants in the current study were assessed as meeting the requirements for Step 3 treatment. As such they were likely to be experiencing moderate to severe symptoms of their primary presenting problem, or have presented with complicating factors requiring intensive treatment. By way of

contrast, McLellan et al.'s (2019) sample was drawn from a primarily research sample of people attending a study for group treatment Social Anxiety Disorder. Whilst McLellan et al. (2019) did recruit from a clinical population this was a research specific group, which may have allowed for more selective recruitment than either the current study or McLellan et al.'s (2021) study. It was also conducted on participants attending group therapy for social phobia, which raises the possibility of the restricted symptom group accounting for the difference. Unfortunately, due to the lower than originally intended sample size and the relatively small number of people attending treatment for Social Phobia during the current study (perhaps a consequence of reduced social contact due to Covid-19), it was not possible to run analysis solely on participants presenting with this disorder.

The closest parallel between previous CBT-Suits study populations and the current one was McLellan et al.'s (2021) study. This also drew from a real world clinical population, that of referrals to an Australian health centre. However, like the current study McLellan et al. (2021) did not find any significant predictive validity for the CBT-Suits with regard to treatment outcomes.

Another possible explanation for the differences in results between McLellan et al.'s (2019) study and the current one is the increased level of correlation between the CBT-Suits and baseline symptom severity measures found in the current study, compared to those carried out by McLellan et al. (2019). Both the current study and that conducted by McLellan et al. (2021) (which as previously discussed did not find any predictive validity for the CBT-Suits) identified significant correlations between CBT-Suits factor scores and pre-treatment PHQ-9 and GAD-7 scores of participants. In contrast McLellan et al. (2019) did not find any significant correlations of this type. Once again, a possible explanation for this may come from the study populations. As previously noted, McLellan et al.'s (2019) study was drawn from a study sample of attendees for group CBT for social anxiety, whereas the current study and McLellan et al. (2021) both drew from a 'real world' clinical sample. It is possible therefore that the selective intake of McLellan et al.'s (2019) study may have resulted in a restrictive range of symptom severity scores. If this occurred then it is likely that such a restrictive range could have resulted in a reduced correlation coefficient (Bland & Altman, 2011).

Finally, as mentioned above, there was a difference in the treatments offered by McLellan et al. (2019), McLellan et al. (2021), and the current study. As previously discussed, participants in McLellan et al.'s (2019) study were offered face to face group treatment for Social Anxiety, which was not offered in the current study. By way of contrast both McLellan et al. (2021) and the current study offered individual therapy, either wholly or substantially over the internet (in the case of the current study due to a move to remote working due to the Covid-19 pandemic). Given this it is possible that the CBT-Suits may be more useful in predicting outcomes in face to face group treatments than individual internet based therapy.

Reliability and validity of the CBT Suits

Whilst the reliability of the CBT Suits scale was measured by calculating Cronbach's α (see results table 5), construct validity, or how well the scales measure what they purport to, was not tested for specifically. However, arguably, the failure of this measure to show predictive validity, raises questions about its construct validity given that the purported aim of the CBT-Suits is to measure suitability for CBT.

Relationship to existing literature

The lack of evidence for predictive validity for the CBT-Suits is surprising but on deeper inspection of the existing literature, understandable. As discussed in Chapter 1 of this thesis, the evidence for non-clinical, attitudinal and personality based predictors of outcomes in individual CBT is far from conclusive, with no single factor or scale unequivocally predicting outcomes in all studies. When compared to existing studies the CBT-Suits would best fit into what has previously been described as "beliefs about illness" in previous chapters. The Rationale and Behaviour factors in particular, which include questions such as "I can change what I do in a situation by changing the way I think about it" and "Even though trying new things is difficult for me, it means things change for the better" imply both a belief in the ability to make change, and a belief in a psychological (rather than biological) source of the illness. The literature review associated with this thesis found very few studies investigating beliefs about illness as a predictor however, with only one (Dusseldorp et al.,

2007) investigating beliefs in participants ability to control their illness. Whilst Dusseldorp et al.'s (2007) study did find a significant relationship between participants' beliefs about the locus of control of their Panic Disorder (American Psychiatric Association, 2013), it is difficult to generalise these results to the current study, both because degree of perceived control of symptoms is regarded as a key component of the CBT model for Panic Disorder (Clark, 1986), and because their results found a U shaped relationship between locus of control and outcomes, rather than a linear one (for a deeper exploration of this see Chapter 1). There is similarly little evidence that beliefs about the psychological rather than biological cause of mental illness are a predictor of outcomes for common mental health problems. Referring again to Chapter 1 of this thesis, only a single study (Dunlop et al., 2011) was found to have investigated this for a sample receiving one to one CBT. Dunlop et al. (2011), however, found no significant relationship between beliefs about the source of Major Depressive Disorder (American Psychiatric Association, 2013) and therapy outcomes.

Studies corresponding to the Insight subscale are even fewer. Links to the research base can be found by examining the other cross diagnostic outcome prediction tool the Suitability for Short Term Cognitive Therapy Scale (SSCT) (Safran et al., 1993). As discussed in the introduction section of this chapter, the CBT-Suits structure bears a degree of similarity to the SSCT, and factors on that scale, such as accessibility of "automatic thoughts and "awareness and differentiation of emotion" (Safran et al., 1990, p231) bear particular resemblance to the Insight scale, which includes questions such as "I am able to be really aware of how I am feeling" and "I put my thoughts into words". Whilst the SSCT has been validated as predictive of outcomes in CBT, exactly which aspects of it are predictive is not clear, as dismantling studies by Myhr et al. (2007) and Renaud et al. (2014) found only slight overlap in their results (for a more in depth exploration of this see chapter 1). Unfortunately, those factors that are more clearly evidenced as being predictive of outcome are also the most difficult to measure using a pre-treatment questionnaire. The therapeutic relationship in particular has been shown to be predictive of outcomes in a number of studies (Cameron et al., 2018), but as this is a product of both the therapist and the client it is difficult to accurately predict this before the start of therapy (although the potential for therapist competency to influence this are discussed in Chapter 6). Potential for

alliance and acceptance of responsibility for change are both identified as items in the SSCT however and should a means of assessing these through a pre-treatment questionnaire be found then they may add significant predictive value to the CBT-Suits.

Limitations of the study

Data collection in service based clinical studies

As a result of the service-based nature of this research, the collection of routine clinical outcome data was conducted by the clinicians providing the therapy in the study. As such despite therapists being blind to the CBT-Suits scores, routine outcome data were not collected blind and were subject to clinical targets.

Participant recruitment

The planned sample size for this study was 300, significantly larger than that achieved in practice. Whilst this did not seem to negatively affect the CFA, it is possible that a larger sample size could have detected a small effect size when investigating the predictive validity of the CBT-Suits for treatment outcomes. However, as previously stated, it is unlikely that such an effect size would be large enough to be of practical use in a clinical setting.

Had sample size been larger though, it would also have been possible to conduct more in depth analysis of secondary variables such as demographics or experiences of previous treatment. Had sample size allowed this to be done in a meaningful way it would have been possible to have explored any variation in CBT-Suits or symptom severity scores recorded, for demographic or treatment type variables, differences in treatment outcomes, and whether there were any variations in the predictive validity of the CBT-Suits for each of these groups. Of particular import, however, was that there was not enough power to undertake comparative analyses between different anxiety disorders and measures. In addition to the GAD-7 and PHQ-9, NHS IAPT services also make use of a number of Anxiety Disorder Specific Measures for specific anxiety disorders (National Collaborating Centre for Mental Health, 2021), such as Social Anxiety, Post-Traumatic Stress Disorder and Obsessive

Compulsive Disorder. Had power allowed, it would have been useful to explore any variations in predictive validity using these outcome measures. This would been of particular interest in comparing data for the treatment of Social Anxiety Disorder with that found by McLellan et al. (2019).

There were multiple reasons why the study was not able to recruit as many participants as desired. Firstly, the participant recruitment was severely hampered by the Covid-19 pandemic, the lockdown response and their implications for healthcare provision. These factors resulted in a move by the participating service away from face to face appointments and towards virtual therapy over video link. This made recruitment via paper forms, which were completed with the client in session, very difficult, and participants recruited in this way reduced to zero following the shift. The second potential impact of Covid-19 on recruitment was its effect on service provision. The pandemic and its associated lockdowns had a wide reaching effect on the mental health needs of the UK population, and service responses such as the setting up of virtual therapy, staff support hubs, hospital outreach and long Covid centres, alongside a 30% increase in referrals, had a significant impact on the time and attention that service leads were able to allocate to research and recruitment. Alongside these factors, increases in work and Covid-19 related stress experienced by participating therapists may also have had an impact, though, as previously stated, recruitment had effectively become automated at this stage.

Other consequences of conducting the study in lockdown

The Covid-19 lockdown may also have impacted the study in other ways. In particular the nationwide lockdowns affected the way therapy is conducted. Although the move from face to face, to video-conferencing therapy was unexpected, and required changes to the study protocol, it is unlikely to have had a significant impact on treatment outcomes, as videoconferencing has been shown to be an equally effective method of delivery for CBT as in person appointments (Day & Schneider, 2002; Griffiths et al., 2006; Manchanda & McLaren, 1998; Simpson, 2009). However, the effect of lockdown was such that it was substantially more difficult for recipients of therapy to engage in a range therapy related behaviours, such as social interaction (for the treatment of social, and other,

anxiety disorders), graded exposure to stimuli outside of people's homes (as required in agoraphobia) or participation in meaningful and rewarding activity (part of the treatment for depression). Whilst direct evidence of this effect is neither currently available, nor within the scope of the current study, evidence for the relationship between homework task completion and outcomes in CBT is strong (Kazantzis et al., 2010). However, information collected by the participating service did not indicate a profound reduction in recovery rates during this period. It was hypothesised within the service leadership that this may have related to a noticed decrease in nonattendance at therapy and dropout rates over the course of treatment, perhaps due to a reduction in alternative activity for therapy recipients to engage in during lockdown, or an increased focus on mental health during this period. As such, whilst it is not possible to determine whether the inability of therapy recipients to engage in therapy related activity influenced their recovery, it is clear that the predictive validity analysis did not compare CBT-Suits scores with the "full" and evidence based CBT treatment models.

Implications of findings and recommendations for future research

Data from this study suggest that the 11 question CBT-Suits questionnaire is the most parsimonious and has the best fitting factor structure. However, there is no evidence that the Suits11 provides any predictive validity over and above that of initial symptom severity measures in predicting CBT outcomes in UK IAPT services, at least as they were run during the Covid-19 pandemic. These outcomes concord with a much larger study by McLellan et al. (2021), which achieved similar results. As such there is not good evidence to support the use of the CBT-Suits as an assessment tool in NHS IAPT service in its current form and without further research. Whilst the CBT-Suits itself has not been shown to be a practical tool for the prediction of outcomes in a clinical setting, its theoretic foundations are strong. As identified in Chapter 1, a range of non-clinical individual factors have been shown to predict outcomes in CBT. Further research into the relationship between these factors, such as optimism and credibility of therapy, the ability to form relationships, and acceptance of responsibility for change, as well as the factors identified in the development of the CBT Suits, is recommended.

Conclusions

This study has added to existing knowledge in the field through confirming the factor structure of the CBT- Suits questionnaire in a UK IAPT sample. It has also served to indicate that the CBT-Suits does not currently have an evidence base for use as an effective tool for use in the screening and assessment of referees for CBT in this context. This suggests that it would not be effective, without further study, to integrate the CBT-Suits into the Stepped Care model in NHS IAPT services to assist in allocation of cases to Step 2 or Step 3.

Section 2

Introduction

Recall that, as Section 1 of this thesis explores the practical applications of client factors that may improve the provision of CBT services, Section 2 approaches this subject from the perspective of the training and development of the therapist. To refresh the mind of the reader, whilst the definition and measurement of competence in CBT are complex and the subject of much discussion, there is evidence base for a positive relationship between therapist competence and client outcomes. Further, given the practical focus of this thesis, therapist competence is something that is, to a degree under the control (or at least influence) of the service, through constructs such as training, CPD and supervision. However, training and CPD are not free and come at a cost to both service delivery (in terms of time taken away from clinical work) and potentially subject the trainee to both emotional and mental stress (Bennett-Levy et al., 2003; Colford, 1989). As such it is important that such training be of demonstrable use to both the service and therapist, in terms of improving the quality of CBT provision.

In line with the requirements of the PhD in Professional Practice, Section 2 explores the provision of training and CBT from a practice based perspective. Chapter 4 (the service related study) evaluates the training and supervision of junior doctors (first year core psychiatry trainees) in order to prepare and support them through the process of undertaking their first CBT case. It evaluates changes in therapy competence as assessed using both Royal College of Psychiatry measurement tools, and as self-assessed by the trainees themselves. Further it employs qualitative methods to explore the experiences of the trainees, focusing on their support and training needs throughout the programme and considering changes based on their recommendations.

Chapter 5 (the report of the author's personal practice) utilises a Reflective Topical Autobiographical (Johnstone, 1999) design to explore the experiences of a skilled CBT therapist (the author), whilst undertaking an evidence based CPD programme known as Self Practice and Self Reflection (Bennett-Levy et al., 2001; t-Levy et al., 2015). As with Chapter 4, Chapter 5 assesses changes in perceived competence of the participant over the course of the programme but focuses

more heavily on their experiences whilst undertaking it, and the practical strictures placed on their ability to engage in the programme whilst leading a busy clinical team. As such, whilst both studies investigate the perceived changes in competence of the participants of the programmes, the main focus of both is to explore their experiences of learning, support needs and their relation to the needs of clients and participating services, in order that they might be evaluated as practical tools for the training and development of the professional groups represented in the studies.

Chapter 4

Evaluation of Core Psychiatry Trainee Short Case Training in Cognitive Behavioural Therapy in an NHS Foundation Trust

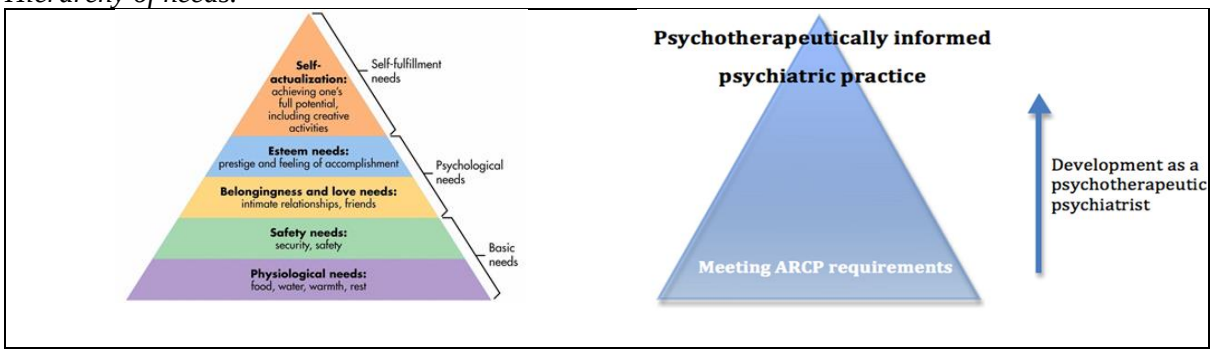
A note on confidentiality

No service user or participant identifiable data have been retained in this paper.

Introduction

The development of psychotherapeutic competencies is a key feature in psychiatric training and is regarded as essential for the delivery and ongoing improvement of psychiatric services (Awal, 2016). For this reason, psychotherapy training is mandatory for all core psychiatry trainees (CT1-3) (Royal College of Psychiatrists, 2015). Awal (2016) describes this process as a trainee's "development as a psychotherapeutic psychiatrist" (p.2) and relates the training to Maslow's hierarchy of needs (Maslow, 1943), with basic core competencies for psychiatric practice at the base of the hierarchy (relating to the *basic needs* of a psychiatrist) and psychotherapeutically informed practice equating to Maslow's concept of a self-actualised individual at the top (see figure 1). Awal regards the key foundations of the development of a psychotherapeutic psychiatrist to be the ability to think psychologically, to take a reflective and psychotherapeutic approach to routine psychiatric practice, and to respond to the emotional complexities of service users with greater understanding

Figure 1.
Awal's (2016) Psychotherapeutically Informed Practice model (right) as it relates to Maslow's Hierarchy of needs.



(left image copied from https://www.simplypsychology.org/maslow.html)

Overview of Psychiatric Training in the United Kingdom (UK)

To help set these foundations in context, it is useful to outline the nature of UK psychiatric training in more detail. The training and role of psychiatrists in the UK is very different to that of psychologists and (most) psychotherapists. Whilst psychologists and psychotherapists are trained extensively in psychological and psychotherapeutic assessment and interventions, the majority of psychiatric training is in medical interventions following the biopsychosocial model (Royal College of Psychiatrists, 2015). As such, most psychiatrists enter their training with very little previous psychotherapy experience and only undertake a limited amount of psychotherapy training during their careers. Psychiatric training in the UK is broken down into four stages, as follows (Royal College of Psychiatrists, 2018).

1. First, all applicants must complete a relevant medical degree, taking four to six years.
2. On graduation from their degree, all medical trainees enter a paid, two-year, foundation programme (FY1 -2) in which they undertake a number of specialist placements, designed to help them gain the experience necessary to choose a specialty at the end of this period.
3. On specialising in psychiatry, trainees begin a three-year core training programme (CT1-3) in which they gain experience of a range of psychiatric sub-specialties, including psychotherapy.
4. On completion of their core training, trainees undertake a further three-year training programme (ST 4-6) in the psychiatric sub-specialty of their choice. It is at this stage that some psychiatry trainees, specialising in psychotherapy, will undertake further training analogous to that undertaken by non-psychiatric psychotherapists in their chosen field.

On completion of this twelve to fourteen year process, trainees are eligible to be employed in consultant psychiatry posts of their chosen sub-speciality. Each stage of the process is designed to give the trainee the skills that will be necessary for them to build on at the subsequent stage of their development. Foundation level trainees, for example, receive training in listening and medical assessment skills, enabling them to develop more specialist psychological skills in the Core and Specialist years. By the same token, the majority of Core trainees will not go on to specialise in Psychotherapy. As such, the aim of the Core psychotherapy training programme is not to teach

trainees to be psychotherapists, but to help them to develop an understanding of the different psychotherapy models sufficient to recognise when it would be appropriate for service users, and to develop the knowledge and skills that would enable them to develop as a psychotherapeutic psychiatrist.

Psychotherapy requirements of core training

Core training requires that trainees undertake one long (21 or more sessions) and one short (12-20) session psychotherapy case in two different modalities. This casework primarily relates to four of the core Independent Learning Outcomes (ILOs) that trainees are required to demonstrate. Summarised these are:

"ILO 3: Demonstrate the ability to recommend relevant investigation and treatment." (p.37)

"ILO 5: Demonstrate the ability to conduct therapeutic interviews… [and]… to conduct a range of individual, group and family therapies using standard accepted models." (p.37)

"ILO 8: Use effective communication with patients, relatives and colleagues … [including]…the formation of therapeutic alliances" (p.38)

"ILO 19: To develop reflective practice including self-reflection" (p.38)

(Royal College of Psychiatrists, 2015, pp.37-38; Relevant ILOs are given in full in Appendix D).

In order to meet these competencies, core trainees are required to provide in depth and high quality psychotherapy with limited training and (frequently) little or no previous experience of psychotherapy and this can present training departments with a number of challenges. In terms of CBT (the psychotherapy utilised for short case training in the participating NHS Mental Health Trust, hereafter referred to as "the Trust") this has particular implications for the level and focus of training provided. Traditionally CBT training is conducted in one of two formats, longer courses designed to enable practitioners to undertake full "in depth" therapy, personalised to service user's needs, and conforming with disorder specific evidence-based protocols; or shorter, brief training designed to enable (usually less experienced) practitioners to undertake CBT based techniques and interventions (British Association for Behavioural and Cognitive Psychotherapies, 2017; British Association for

Behavioural and Cognitive Psychotherapies 2018). Frequently known as Low Intensity or CBT interventions training, these latter programmes tend to focus on the rapid identification of a specific issue within the service user's presentation and the application of specific short term, and frequently simplified, treatment interventions such as problem solving, cognitive restructuring for a specific issue, or simple behavioural treatments. Such CBT Interventions training has less of an emphasis on the formulation, interpersonal and therapeutic relationship skills that CT1-3 Core psychiatry training requires, making it unsuitable for core trainees. Neither is there time (or a need) for trainees to receive full psychotherapy training before choosing a specialism in their later years. As such it is necessary to provide a bespoke training package tailored to meet core trainee needs within the limited time available in the curriculum. Given the degree of knowledge and skill that needs to be developed during this training it is particularly important that trainees receive both appropriate support and supervision throughout their psychotherapy casework; and that training is developed in line with evidence based practice, in order to maximise its effectiveness.

Ethics of Psychotherapy Training in the Core Psychiatry Programme

Whilst the Core Psychiatry programme is designed to develop future psychiatrists' skills as psychotherapeutic practitioners, it is reasonable to raise questions about the ethics of allowing junior practitioners of any profession to practice treatments in which they have limited experience and training with members of the public, particularly those who may be vulnerable due to illness. In this context the balance of future beneficence with current risk of harm must always be held in mind. Jagsi and Lehmann (2004) posit that this dilemma is similar to that presented by medical research. They argue that such training should be guided by three underlying principles; those of *Respect for Individuals*, including informing prospective patients of the practitioners' trainee status and procedures for gaining informed consent; *Beneficence*, including the minimisation of risk and careful selection of patients; and *Distributive Justice*, ensuring that the "burden" of receiving treatment from a trainee is not biased. In the case of this study, all of these factors were attended to. All patients treated by trainee psychiatrists were informed of their status, limited training in psychotherapy and arrangements for supervision before treatment began, and given the option of an alternative

practitioner at all stages of the treatment; patients were carefully selected and reviewed by both the lead supervisor and on-placement medical supervisors as to their suitability for treatment by a trainee; and efforts were taken to ensure that recipients of treatment were selected on the basis of their clinical need and presentation, rather than specific demographic traits. It can also be argued that the study itself also adds to the principle of *Beneficence* as its aim is to review the quality of the training provided, thus minimising risks to patients and enabling best practice to be developed based on the results (see chapter discussion).

Service context

Like the many training providers (Agarwal et al. 2007; Podlejska-Eyres & Stern, 2003), the participating Trust requires trainees to complete their long case in Psychodynamic Psychotherapy and their short case in CBT. Guidelines for the training and supervision of these cases require that a Consultant Psychiatrist in Medical Psychotherapy be appointed as a Psychotherapy Tutor to oversee psychotherapy training. This tutor then appoints one or more psychotherapy (clinical) supervisors to oversee clinical cases in specific modalities.

In order to maximise the benefits for trainees and service users, the Trust opted to employ a specialist CBT therapist (the author and programme developer) with training and supervisory experience, to provide training and supervision for the CBT short case. Prior to this, training and supervision was conducted by Clinical Psychologists working in the teams that trainees were placed or treated service users in. It was recognised, however, that this presented a number of challenges at a systems level for both the supervising psychologists, for whom this was not part of their core responsibilities, and for trainees in terms of finding supervisors willing to train them. It also raised issues regarding the consistency and quality of training and supervision, as this depended greatly on the good will, time commitments and CBT experience of the supervising psychologists, many of whom were not specialists in this modality.

Relationship between therapist competence and efficacy of therapy

Whilst definitions of competence may vary (see thesis introduction), the need for therapists providing therapy to be competent to the required level is clearly evidenced. Differences between individual therapists, for example, have been shown to relate significantly to psychotherapeutic outcomes. Cross modality meta analyses indicate that therapist variables may account for between 5% (Baldwin and Imel, 2013) and 8.6% (Crits-Christoph et al., 1991) of variance in therapy outcomes, with therapist experience accounting for a significant portion of that variance in Crits-Christoph et al.'s (1991) study. In particular, as discussed in the introduction to this thesis, there is evidence that short training courses provided to novices in CBT can correlate with positive outcomes for clients. (Simons et al., 2000; Westbrook et al., 2008).

As with Simons et al.'s (2000) and Westbrook et al.'s (2008) studies, the evaluated programme was not designed to train the participants to the level of fully qualified psychotherapists. However, the Trust was still required to provide service users with competent treatment under its duty of care "to ensure a professional and consistent level of care is provided to all patients" (National Centre for Social Research, 2012, p.2). Given the trainees' lack of experience in psychotherapy and the very limited time available to train them it was necessary to develop a highly structured training and supervision programme that drew on existing theory and evidence.

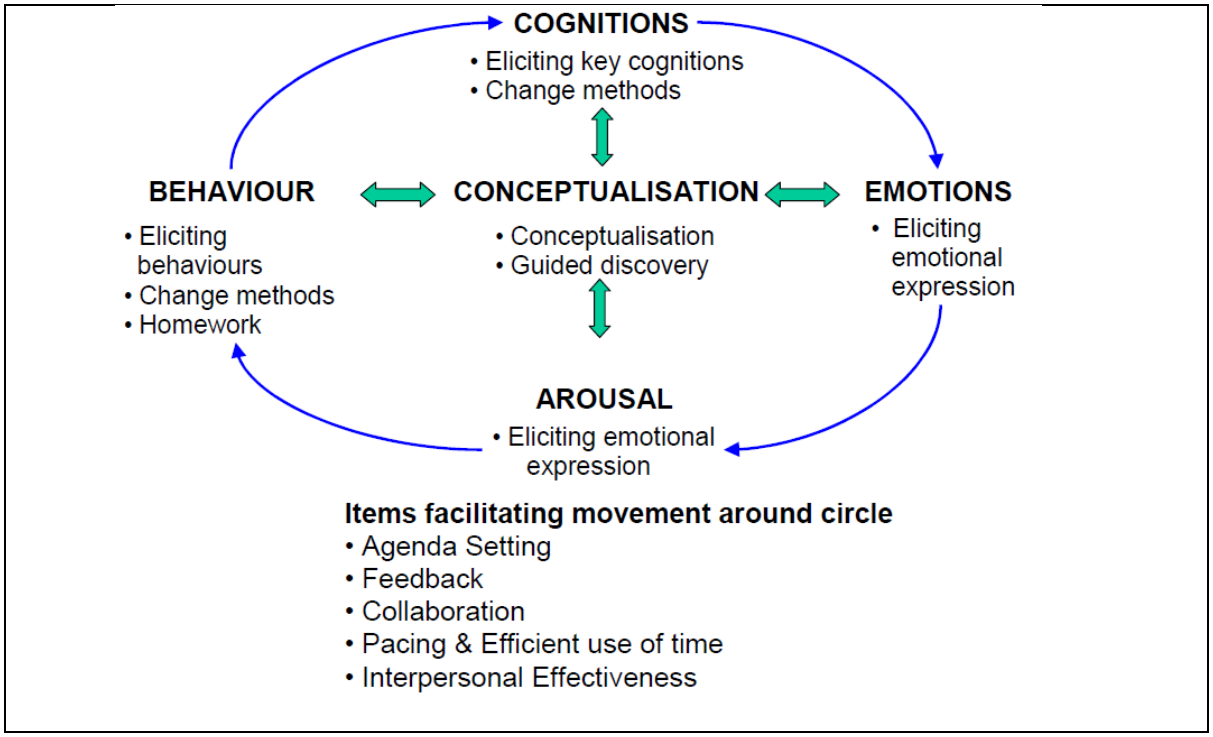
Development of the Training and Supervision Programme

Studies of therapy training (Bennett- Levy, 2006) suggest that therapy knowledge and skills are best developed using different methods. Bennett-Levy's Declarative/Procedural/Reflective (DPR) model draws heavily on Binder's (1992) training model which is, in turn based on the declarative (factual) and procedural (practical) processing systems. Bennett-Levy surmises that whilst formal didactic teaching may be highly adapted to the development of declarative learning, such as theoretical models, it may be less well suited to skills development, which corresponds with the procedural system and is more suited to experiential learning such as role plays or experimentation. The third component of Benett-Levy's model relates to reflection, which he regards as the most important learning mechanism for experienced therapists. The DPR model also draws heavily on Kolb's (1984) experiential leaning model. This model suggests that reflective observation of concrete

experience enables the development of abstract concepts about the experience, which form the basis of further experimenting and learning. Based on these concepts, Bennett-Levy et al. (2001) went on to develop a model of Self Practice and Self Reflection (SPSR) (discussed in depth in Chapter 5 of this thesis), positing that therapists of all levels of experience can use their CBT skills on themselves in order to develop their own practice and wellbeing. This was felt to be particularly important in the development of the core training programme as trainees were asked to relate their experiences and learning to their wider psychiatric work, a process that Kolb's theory suggests would be facilitated by the reflection and abstract conceptualisation involved in SPSR.

The training programme developed by the author was therefore designed by primarily drawing on the DPR model. The author started from the assumption that trainees had already developed basic skills in communication and assessment during their foundation years as required by their training to this point (Royal College of Psychiatrists, 2015), although this was continually assessed throughout supervision. This enabled the programme to focus on more model specific skills and techniques. Central to this was the need to ensure that the training covered core CBT concepts, such as case conceptualisation and identification of cognitions, emotions and behaviour; and process and structure skills, such as agenda setting, feedback, collaboration, and use of self, that enable the therapist to help their client work through the cognitive/behavioural cycle. The author drew heavily on both the core competences for CBT for anxiety and depressive disorders collated by Roth and Pilling (2008b), and the Cognitive Therapy Scale – Revised (Blackburn et al., 2001), a widely used model for the development of CBT skills that divides skill development in this way. Figure 2 displays Blackburn et al.'s view of the relationship between the key CBT concepts and the skills required to conduct effective therapy.

Figure 2.
The relationship between the CTS-R items and the Cognitive Cycle



(image from, James et al., 2001, p.2)

Following this model, it was clear that trainees would require both knowledge based teaching in the basics of CBT theory and experiential skills training to meet both the required objective for their casework, and the duty of care that the Trust had to service users receiving therapy. This was particularly important as, in line with other junior doctor training, it was Trust policy that service-users were recruited from those referred for psychological therapy within the service and rather than a specialist pool who had volunteered to work with trainees.

In order to best prepare trainees for their CBT case, a three-part training programme was developed and facilitated by the author, drawing on the DPR and SPSR models, as well Awal's (2016) model of the development of the psychotherapeutic psychotherapist.

1) Introduction to CBT training.

This consisted of three two hour workshops covering:

a. core concepts of CBT;

b. structure of typical one hour CBT sessions;

c. basic assessment and formulation using CBT skills and techniques;

d. communication, therapeutic relationship and guided discovery (Padesky, 1993) skills;

e. core CBT interventions including Cognitive Restructuring (Beck, Rush, Shaw & Emery, 1979), Graded Exposure for Anxiety and Behavioural Activation for depression (Jacobson, et al., 2001).

2) Structured supervision

This consisted of approximately 1.5 hours per week of group or individual supervision per trainee therapy session (totalling 15-24 hours). This focused on a range of areas, including

a. the development of core skills of listening, guided discovery and empathy;
b. session planning and structure;
c. idiosyncratic and disorder specific formulation using evidence based models;
d. ongoing treatment interventions based on idiosyncratic formulation and evidence based models;
e. risk assessment and management.

Supervision was based on the evidence based model developed by Milne (2009), in which the supervisor was trained. Sessions followed a broad structure similar to that of a CBT session with educational, experiential, and reflective components.

3) Self-Practice and Self-Reflection

This was incorporated throughout the programme. For example, during the initial workshops trainees were asked to formulate their own experiences in their everyday psychiatry practice and reflect on their use of structure and communication skills. This was then developed during the supervision process once therapy had begun, through the use of reflective supervision, process analysis of audio or live therapy, and self-practice tasks.

Clearly, given the time allowed for the programme it was not possible to engage in the material in as great a depth as would be provided by a full CBT psychotherapy training course. Supervision was therefore essential in helping the supervisor and trainees focus the learning on the specific aspects of the trainee's cases as they evolved. This resulted in a degree of variation in the training that was provided in supervision. A trainee who was treating an individual with Social Anxiety Disorder (American Psychiatric Association, 2013), for example, would receive relatively in

depth teaching on the treatment of this disorder, but comparatively little on another disorder such as Obsessive Compulsive Disorder (American Psychiatric Association, 2013), and vice versa. This was mitigated to a degree by the group supervision process however, in which trainees were able to learn from the experiences of, and teaching provided to their peers, who were often treating service users with different presenting problems.

As required by the Royal College of Psychiatrists (2015, as cited in Awal, 2016) and the Trust, at the end of their short case, trainees were assessed by the author using two measures: the Structured Assessment of Psychotherapy Expertise (SAPE) (Royal College of Psychiatrists, 2015, as cited in Awal, 2016) and the Psychotherapy Assessment of Clinical Expertise (PACE) (Royal College of Psychiatrists, 2015, as cited in Awal, 2016). These are used to assess trainee practice in the areas of attitude, theoretical understanding, formulation skills, empathy, time management, use of techniques, ending therapy and use of supervision (see Appendix E and the measures section below for further details). Assessment was informed throughout trainee cases via live or audio observation of their work and via an assessment session with their supervisor in which they were asked to reflect on their work and how they would be able to integrate learning into their day to day practice.

Evidence base for psychiatric psychotherapy training

Research and evaluation into psychotherapy training for psychiatric trainees is extremely limited and, due to its age, frequently relates to outdated guidelines and working practices. That which is available highlights a number of similar themes however, such as the importance of consistent access to appropriate supervision and training (Carley & Mitchison, 2006; Hwang & Drummond, 1996; Podlejska-Eyres & Stern, 2003). Evaluation of short case CBT training in psychiatry is even scarcer, as the above studies drew on trainees' experiences of the psychiatric psychotherapy training programme as a whole. Only one evaluation of UK core psychiatry trainees' experiences of short case psychotherapy training was identified in the literature. Carson and Clark (2017) conducted a purely qualitative evaluation of core trainee experiences of short case CBT training in a different UK deanery, using semi structured interviews. Participants in their study were broadly positive about their experiences and highlighted the role of supervision and guidance in their development. Participants

identified the acquisition of a range of core CBT skills and knowledge, and many expressed an increased confidence in relation to CBT. Carson and Clark (2017) also identified a number of barriers to learning in their evaluation, including time management issues, and client availability and engagement issues. Whilst Carson and Clark's (2017) study identifies a number of important themes in trainee experience, the study has a number of limitations. First, being solely concerned with broad qualitative feedback from trainees it does not discuss the development of the programme in terms of the underlying theories of therapy training or address the relative merits of different aspects of the programme. Additionally, as they were only interested in trainee experiences Carson and Clark's (2017) study did not evaluate the success of the training in terms of meeting Royal College of Psychiatrist's competency benchmarks.

Rationale for the Current Evaluation

The conduct of evaluation into existing practice is broadly accepted as an appropriate means of gathering information about changes that occur over the course of training programmes (Alkin, 1970; Kirkpatrick & Kirkpatrick, 1994). Evaluation of health training is also in line with the third and seventh principles of the National Health Service Core Values (National Health Service, 2015), to aspire *"to the highest standards of excellence and professionalism*"(Principle 3) and to provide *"best value for taxpayers' money and the most effective, fair and sustainable use of finite resources"* (Principle 7).

As discussed above, previous evaluations of short case psychiatric psychotherapy training are either so broad as to encompass the psychotherapy training as a whole, thereby lacking the specific focus of an evaluation of a specific programme or are wholly qualitative and of a different programme to the one being evaluated in this paper. No evaluation of the short case programme addressed in this study has been completed to date. The current study seeks to address the limitations of those discussed in the previous section, by gathering quantitative feedback relating to; trainees perceived competence following the programme in a range of CBT competencies; trainees' perceptions of the quality and importance of different aspects of that training in developing those competencies; and exploring qualitative feedback from trainees regarding their experiences on the programme delivered. It will

also investigate the whether the programme meets its core purpose in facilitating trainees in the attainment and demonstration of the competencies required of them at this stage of their training.

Research Questions (RQs)

- RQ 1: Do trainees who have completed the CBT Short Case training and supervision programme attain the level of competence required to meet Royal College of Psychiatrists benchmarks?
- RQ 2: How do trainees who have completed the training and supervision programme rate their competence in twelve Core CBT competencies before they undertook the programme, at the time they completed their case and at the time of completing the evaluation, and what is the relationship between these ratings?
- RQ 3: What were trainees' perceptions of the quality of the taught and supervisory components of the CBT short case training and supervision programme and how important did trainees perceive these components to be for facilitating skills and knowledge development?
- RQ 4: What reflections do trainees have on their experience undertaking the CBT short case training and supervision programme?

Method

Participants and Recruitment

Twenty two Core Trainees had completed the Short Case Training Programme between its inception in 2012 and the date of this study. All these trainees were emailed by the investigator and invited to participate in the study by completing the Experiences of CBT Training and Supervision Questionnaire (ECTSQ). A consent and information form was attached (see Appendix F) which informed potential participants that consent to participate would be identified by their completion and return of the questionnaire. Questionnaires were returned to a third party who anonymised them and gave each a study identifier (letter A-K). Programme completers were later emailed to request that

their PACE and SAPE assessments, also be used in an anonymised form. Eleven trainees completed and returned the ECTSQ.

Six of the respondents to the ECTSQ identified as female and four as male, one did not identify their sex. Respondent ages ranged from 28 to 43 years with a median age of 30 (interquartile range 1.75). One respondent did not identify their age. All participants identified that they had received supervision, however three recorded that they had not attended the taught sessions provided by the Trust. Three participants had attended additional training provided by the medical school. One participant had previous experience of CBT and one had received further training in CBT since completing the programme. Time since completing the programme raged from 0-3 months, to over one year (median 7-12 months; note that these data were collected in time bands).

Nine trainees gave permission for the study to make use of their PACE and SAPE assessments in an anonymised form. Unfortunately, as requests for access to Royal College of Psychiatrist assessments were made at a different time to the ECTSQ forms, it was not possible to link ECTSQ responses with SAPE and PACE scores. Five of the n=9 group who allowed access to their assessments were female and four male. It was not possible to ascertain other demographics from their portfolios.

The study was approved by the Trust, who judged that it did not require NHS research ethics approval as it met the criteria of a service evaluation.

Study Design

The study utilised mixed methods. RQ1 was investigated by reviewing the supervisor's quantitative evaluations of the trainee's competence that used the Royal College of Psychiatrists assessment tools (SAPE and PACE) at the time of the completion of their short case. RQ2, RQ3 and RQ4 were investigated using the ECTSQ, a post hoc questionnaire that collected both quantitative and qualitative data and was designed for this study by the author. This was done post hoc so evaluations were made with the benefit of hindsight. This was partly for pragmatic reasons (the decision to evaluate was not taken until after the programme had been running for some years), but also in order

to counteract the Dunning Kruger Effect (Kruger, & Dunning, 1999) which leads novice practitioners to overvalue their pre training competence.

Measures

Structured Assessment of Psychotherapy Expertise (SAPE) and Psychotherapy Assessment of Clinical Expertise (PACE).

The SAPE and PACE are the two structured assessments of competence that the Royal College of Psychiatrists uses for the purpose of assessment of psychotherapy at trainee level. The SAPE utilises a ten question Likert style format each with five ratings: unacceptable, much work to be done, borderline, satisfactory and accomplished, in order of degree of competency. The PACE has seven questions and also uses a Likert style format, this time with four ratings: poor, work to be done, satisfactory and good, in order of degree of competence. These were used to assess competency following the programme, as discussed in the introduction, and are included to investigate RQ1 above.

Experiences of CBT Training and Supervision Questionnaire (ECTSQ).

The use of questionnaires is a widely utilised method of evaluating training. Kirkpatrick (1970) identifies four levels that a successful evaluation questionnaire should address;

1. *participant reaction*, or how did they like it?
2. *learning*, or what principles did they take away?
3. *Behaviour*, or what changes were made to job roles following the training; and
4. tangible *results*, in the case of the evaluated programme, did it meet its aims of enabling the trainees to meet the competency requirements set out by the Royal college of Psychiatrists.

(Kirkpatrick, 1970, p21; explanations added by the current author)

The ECTSQ (see Appendix G) was developed by the author of this study in line with these principles, in relation to the research questions already described. Kirkpatrick's fourth level of evaluation "*results*" is addressed by the evaluation of trainees SAPE and PACE assessments as already described. Whilst it does not have reliability and validity data, there were no suitable

alternative questionnaires with such data available in the literature. As such it was necessary to develop a bespoke questionnaire that, had face validity.

Section 1 of the ECTSQ (Questions 1-12; henceforth Q1-Q12), which relates to RQ2, consists of quantitative questions asking participants to rate, on a scale of 1-10 (with one being very poor and 10 being very good) their perception of their skills and knowledge in each of twelve CBT competencies before the programme, immediately after the programme and at the time of completing the questionnaire.

There were a number of issues when identifying competencies for participants to rate themselves against. Whilst it is often regarded as a single therapy, CBT can more accurately be described as an interlinked set of diverse problem specific interventions (Roth & Pilling, 2008b). This can at times make it difficult to identify a core set of competencies to cover all eventualities. In their attempt to identify such a list Roth and Pilling (2008b), on whose work the author drew in developing the ECTSQ competencies, identify that this can be done using a bottom up methodology, identifying what current best practice looks like in clinical settings or a top down one, drawing only from techniques identified in evidence based treatment protocols. Roth and Pilling, utilise the latter of these two approaches, arguing that this a) reinforces evidence based practice, b) limits the, frequently subjective, argument that occurs when trying to identify which competencies are most useful on a practical level, and c) acts to delineate best practice.

Roth and Pilling divided the resultant 57 competencies into five sections: Generic Therapeutic Competencies, Basic CBT Competencies, Specific Behavioural and Cognitive Therapy Techniques, Problem Specific Competencies and Meta-Competencies. Q1-12 of the ECTSQ drew heavily on both these competencies and the Royal College of Psychiatrists learning outcomes, as discussed in the introduction. It was decided, however, that given the large number of competencies, the short duration of the training and supervision programme, and the fact that the trainees were not training to be fully qualified therapists, it would not be appropriate to use all of them verbatim. Rather, whilst some questions (Qs 1-6, 8 and 9) were drawn directly from the competency list others (Qs7 and 11) were developed to integrate a number of competencies, and Q12 was added to investigate the development of self-practice and self-reflection skills.

Respondents were asked to rate their perception of skills and knowledge in hindsight in order to counteract the Dunning Kruger Effect (Kruger, & Dunning, 1999), which indicates that a lack of meta awareness of their own competence leads novice practitioners to over rate their skills and abilities prior to undertaking training (they don't know what they don't know). Whilst the author is not aware of any studies specifically exploring the relationship between hindsight and the Dunning Kruger effect it was hypothesised that by asking participants to compare their current perceived level of competence with that which they believe they had before undertaking the training, the respondents would, arguably, be able to judge this with a better understanding of the skills required (given that, to an extent, they now know what they didn't know).

Section 2 (Q 12 parts a-e) of the ECTSQ, which relates to RQ3, is also quantitative and asks participants to rate on a scale of 1-10 (with 1 being very poor and 10 being very good) the importance of the different aspects of the programme in helping them to develop knowledge and skills in CBT, as well as their perception of the quality of that aspect of the training or supervision provision.

The concluding questions (Q13 (f) to Q17) of the ECTSQ are free feedback questions designed to garner broader reflections from the trainees regarding their experiences on the training programme and relate to RQ4.

Data Analysis

Nonparametric tests were used to analyse all quantitative data as it was ordinal in nature and did not meet the parametric assumptions. As such, medians and interquartile ranges were used as descriptive statistics. An alpha level of $p<.05$ was used for all tests of difference.

Trainee self-assessment of competence (Q1-12)

For trainee self-assessment of competence (Q1-12) Friedman's test of differences among repeated measures and Wilcoxon Signed Ranks were carried out on each question to determine whether there was any difference in ratings across time points.

Trainees' perceptions of the quality of the taught and supervisory components of the programme (Q13)

Wilcoxon Signed Ranks tests were used to determine whether there were any differences between ratings of quality and usefulness for each aspect of the programme.

Trainees' experiences of the CBT short case training programme

Qualitative responses were analysed using content analysis, following the method suggested by Stemler (2001). Data were collapsed across questions due to overlap between responses to different questions. Questionnaire returns were divided into sampling units by separating each response into units describing a single piece of information. Whilst text units were coded separately they were taken in the context of the question asked and the response in its entirety. On the basis of the review of the text units a coding frame (see Appendix H) was inductively created from the data that specified the names of the categories and subcategories, including brief descriptions of each. Text units were applied to the coding frame and analysed by the lead investigator to allow categorisation of emergent data. A random sample of over 25% of text units were cross coded for reliability by the author's supervisor using the coding frame. Cohen's Kappa was calculated to be K=.834 indicating excellent inter rater reliability according to Robson (1993).

Results

Results relating to the ECTSQ will be presented first, in order of their data appearing on the questionnaire. Quantitative data relating to trainee self-assessment of competence will be interpreted first followed by quantitative data relating to trainees' perceptions of the quality and use of different aspects of the programme. Qualitative analysis of trainees' experiences of the training programme will then be presented. Finally, data relating to the supervisor's assessments of trainee competence is presented.

Trainee Self-Assessment of Competence (Q1-12)

Table 1 displays the descriptive statistics relating to participants' perceptions of their change in competence and ability to use learning to reflect on practice and their own lives. It also shows results of Friedman tests of difference between each point of reference.

Table 1

Median and Interquartile ranges with Friedman's ANOVA for questions at each point of reference.

Question		Median (interquartile range)			Friedman's ANOVA
		Before Training	Case completion	Time of Evaluation	
1.	Knowledge of basic principles of CBT and rationale for treatment	3(2)	9(1)	8(1)	$X^2(2)=19.16$***
2.	Knowledge of common cognitive biases relevant to CBT	2(3)	8(2)	8(3)	$X^2(2)=20.49$***
3.	Knowledge of the role of safety seeking behaviours	2(3)	8(2)	8(2)	$X^2(2)=20.97$***
4.	Ability to explain and demonstrate rationale for CBT to clients	2(4)	9(2)	8(2)	$X^2(2)=20.22$***
5.	Ability to structure sessions	1(2)	8(1)	8(2)	$X^2(2)=18.60$***
6.	Ability to use measures and self-monitoring to guide therapy and to monitor outcome	2(4)	8(2)	8(3)	$X^2(2)=20.67$***
7.	Ability to formulate and use this inform treatment	3(4)	8(2)	8(2)	$X^2(2)=18.62$***
8.	Capacity to implement CBT in a manner consonant with its underlying philosophy	1(1)	8(2)	8(3)	$X^2(2)=19.58$***
9.	Capacity to select and apply most appropriate BT & CBT method	1(1)	7(1)	7(2)	$X^2(2)=20.67$***
10.	Ability to ask questions, listen and reflect with clients utilising guided discovery principles and Socratic method.	4(3)	9(2)	8(2)	$X^2(2)=18.82$***
11.	Ability to make use of supervision as a tool for	5(3)	9(2)	9(2)	$X^2(2)=17.88$***

	reflection and for improving practice.				
12.	Ability to reflect on the skills and knowledge learned and apply them to your own life?	#	8(2)	8(2)	#

* p<.05, **p<.01, ***p<.001

Because of the nature of this question it was not appropriate to ascertain a rating for this question from before the programme or to conduct a Friedman's ANOVA with two data points

As can be seen from Table 1, all the tests indicated significant differences (p<.001). All significant differences were calculated to remain significant when taking account of multiple comparisons by applying the Bonferroni adjustment (Dunn, 1961) (.05/12 comparisons=.004). Therefore, a post-hoc analysis using Wilcoxon Signed Rank tests was conducted for each question to identify where the significant difference lay; see Table 2 for details.

Table 2

Wilcoxon Signed Ranks for each data set division

Question		Wilcoxon Signed Rank Test		
		C-B	E-C	E-B
1.	Knowledge of basic principles of CBT and rationale for treatment	Z=-2.97**	Z=-.48	Z=-2.95**
2.	Knowledge of common cognitive biases relevant to CBT	Z=-2.94**	Z=-1.89	Z=-2.95**
3.	Knowledge of the role of safety seeking behaviours	Z=-2.96**	Z=-1.41	Z=-2.95**
4.	Ability to explain and demonstrate rationale for CBT to clients	Z=-2.95**	Z=-.82	Z=-2.95**
5.	Ability to structure sessions	Z=-2.97**	Z=-.79	Z=-2.96**
6.	Ability to use measures and self-monitoring to guide therapy and to monitor outcome	Z=-2.94**	Z=-1.63	Z=-2.94**
7.	Ability to formulate and use this inform treatment	Z=-2.94**	Z=-.33	Z=-2.99**
8.	Capacity to implement CBT in a manner consonant with its underlying philosophy	Z=-2.45**	Z=-1.41	Z=-2.96**

9.	Capacity to select and apply most appropriate BT & CBT method	Z=-2.95**	Z=-1.63	Z=-2.96**
10.	Ability to ask questions, listen and reflect with clients utilising guided discovery principles and Socratic method.	Z=-2.94**	Z=-.54	Z=-2.95**
11.	Ability to make use of supervision as a tool for reflection and for improving practice.	Z=-2.81**	Z=-1.30,	Z=-2.81**
12.	Ability to reflect on the skills and knowledge learned and apply them to your own life?	#	Z=-0.00	#

(B)=Before Training (C)=Case completion (E)=Time of evaluation

* p<.05, **p<.01, ***p<.001 #Because of the nature of the question no before data were collected for this question

As can be seen from Table 2, Wilcoxon Signed Rank Tests indicate that all differences between ratings for baseline and time of completion of the case, and between baseline and time of evaluation are highly significant (p<.01), whilst none of the differences between time of completion of the programme and time of evaluation were significant. This suggests that, at the time of the evaluation participants rated their competence in all aspects of the questionnaire significantly higher after they had completed the course than before they started it and that, in their view, they had been able to retain these skills at the time they completed the questionnaire. All of the significant differences remained significant following adjustment for multiple comparisons using the Bonferroni adjustment (.05/3 comparisons = .017).Effect size was calculated using $r=Z/\sqrt{n_x+n_y}$) (Rosenthal, 1994) for all significant observations. r was greater than .5 in all cases indicating a large effect size (Cohen, 1988).

Trainees' perceptions of the quality of the taught and supervisory components of the programme (Q13)

Q13 related to trainees' perceptions of the quality of the taught and supervisory components of the CBT Short Case training and supervision. Eleven participants responded. Table 3 shows the results.

Table 3

Ratings of Quality and Importance of Aspects of Training in the development of CBT knowledge and skills from 1-10 with 1 being very poor and 10 being very good.

Aspect of Training		Quality	Importance		
		Median (interquartile range)	Knowledge Median (interquartile range)	Skills Median (interquartile range)	Wilcoxon Matched Pairs comparison of knowledge and skills ratings
13a	Formal CBT teaching	9(3)	9(2)	9.5(2.75)	Z=-1.000
13b	Specialist CBT supervision	10(1)	10(1)	10(1)	Z=-1.414
13c	Supervisory Relationship	10(1)	10(1)	10(1)	Z=-0.447
13d	Practical work with clients	8.5(0.75)	9(1.25)	10(1.25)	Z=-1.414
13e	Self-Practice and Reflection	9(1)	9(2)	9(2)	Z=0.000

* p<.05

Responses indicate that all aspects of the course were well received by respondents, with median ratings ranging from 8.5/10 to 10/10, where 1=very poor quality/low importance and 10=very high quality/importance. There were no statically significant differences between perceived importance for the development of knowledge or skills for any aspect of the training.

There was a significant difference between ratings for quality of Specialist Supervision and Quality of Practical work with clients (z=-2.251, p=0.024) but this did not remain significant when accounting for multiple comparisons. There were no other significant differences in ratings for quality or importance between aspects of the programme.

Trainees' experiences of the CBT short case training programme (Q13 (f)-17)

Ten out of eleven respondents answered the qualitative feedback questions 13(f) to 17. Nine categories of commentary were identified. These were Good quality supervision, Structural/process

components of supervision, Quality of teaching, SPSR, Practical work, Challenges, Improvement, Perceived benefits of programme and Positive overall experiences of training

32 subcategories were identified within these. Categories and subcategories are identified, along with number of respondents who made reference to them, in Table 4 below.

Table 4

Total Respondents referring to each Category and subcategory

Category	Subcategory	Total number of respondents who made reference
Good Quality Supervision		9
	Good Quality	9
	Supervisor's skill or knowledge	4
	Supervisor was available	5
	Supervisor was supportive	5
	Positive supervisory relationship	6
	Freedom to ask questions or express worries	3
Structural components of Supervision		5
	Group supervision format	1
	Peer support	1
	Audio Recording	2
	Flexibility in approach to treatment	4
Quality of teaching		4
Self-Practice/Self-Reflection (SPSR)		4
Practical Work		2
Challenges		9
	Challenges: Service user non-attendance/Drop out	3
	Challenges: Service user non completion of homework	1
	Challenges: Trainees perception of knowledge/skills/confidence	3

	Challenges: Uncertainty of direction of therapy	1
	Challenges: Structure and content	1
	Challenges: Managing Risk	1
	Challenges: Client specialist needs	1
	Challenges moving away from medical model	1
Improvement		8
	No Improvement needed	5
	Improvement recommended: delay in starting programme	1
	Improvement recommended: pre-training discussions with former trainees	1
	Improvement recommended: pre-training observations of therapists	1
	Improvement recommended: Access to cases	1
	Improvement recommended: More live supervision	1
Perceived benefits of programme		5
	Training has enabled changes to Practice	4
	Training has improved Skills	4
Positive overall experiences of training		6
	Generally valuable	5
	Compares positively with training in other Trusts	1
	Enjoyable	3

Each of the nine categories is addressed below in greater detail. To aid reading, categories and subcategories are **highlighted in bold** when referenced in the text.

Good quality supervision

Nine respondents made statements pertaining to this category, all of whom made general positive comments about the quality of the supervision. For example, Respondent B stated,

"I think the training/supervision received in (the Trust) was great"

Four positive references were made to the **Supervisor's skill or knowledge**, five indicated that the **supervisor was available** and five reported finding that the **supervisor was supportive**, e.g.

"(The supervisor) was helpful and approachable and very knowledgeable" Respondent G

Six respondents made reference to a **positive supervisory relationship**, e.g.

"The relationship with the supervisor and the delivery of the specialist supervision were key in endowing us with the necessary skills and confidence to be able to provide high quality care and therapy to the client." Respondent I

Three respondents highlighted the **freedom to ask questions or express worries** as a positive aspect of supervision. Respondent A for example noted that the supervisor made it easy *"to ask for help and question things that didn't make sense or I had forgotten"*. Similarly Respondent F stated that they

"felt that the supervision space was geared to allow trainees the ability to air fears and admit when things hadn't gone quite so well or as well as expected"

Structural/process components of supervision

Five responders made positive statements regarding the **structural components of supervision**. Of these, Respondent F made a positive reference to the **group supervision format** and also reflected on the benefits of **peer support**.

"We were able to provide solidarity and support to each other when listening to cases."

Two respondents reported finding listening to audio recordings of their therapy sessions in supervision helpful. Once again Respondent F noted

"Whilst the voice recording was anxiety-provoking for us trainees, it proved an invaluable tool"

Four trainees made positive reference to **flexibility in the approach** to treatment by the supervisor. Respondent G, for example reported appreciating

"being given examples of different approaches to take"

Quality of Teaching

Four respondents made positive references regarding the **quality of teaching,** Respondent B commented,

"I appreciated the teaching sessions delivered by my supervisors which helped me understand better the process"

This highlighted the role of declarative learning in the training programme. It was not clear whether this feedback related solely to the taught sessions at the beginning of the programme however, as a degree of theory teaching continued into the supervision arena. Whilst one respondent (B) made explicit reference to the

"*CBT Teaching sessions prior to starting the case*" when discussing what helped her overcome challenges in her practical work, another (G) related that the supervision was positive as it "*gave theoretical teaching (and) a place for reflection and guidance"*.

Self-Practice and Self Reflection

Four respondents identified **SPSR** as a helpful component of the programme. Respondent D for example stated that they appreciated

"Good supervision, allowing time to reflect and improve the understanding of self and patient"

Practical Work

Perhaps surprisingly only two respondents made reference to the practical benefits of the case work itself, and both of these were made in broad comments relating to Q13 (in which practical work was identified as one on the learning domains of the programme). Respondent I, for example noted,

"*I feel that all of the domains stated above were critical in being able to develop competency with CBT*."

Challenges

Nine participants responded to the question asking them to identify challenges faced in the programme. Of these, three comments were made regarding **service user non-attendance and drop out**. For example, Respondent J commented that,

"*Initially, I had 2 clients drop out of CBT which was very frustrating for me."*

Similarly, Respondent I referenced difficulties when service users struggled to engage in the **homework** process (an essential component of CBT).

"The client would not always complete the suggested homework tasks."

A number of challenges also related to trainee's perception of their initial skill level or to technical aspects of therapy provision. Three respondents made reference to their perceived lack of confidence or experience. For example, Respondent B said that

"*As a CT1 my knowledge on CBT was very limited",*

and Respondent F stated that they *"felt very nervous and a little unsure of what to expect"* at first but that they *"quickly gained confidence and skills".*

One reference was made by to "*uncertainty in the direction of therapy"* (Respondent E), one to *"Moving away from the medical model and information gathering"* (Respondent G), and one to finding *"the structuring and content of CBT difficult"* (Respondent H).

Two references were made to service user presentation. Respondent F highlighted that *"my allocated client had some fairly high **risks** involved in his presentation".* The second reference, from Respondent J related to challenges working with a service user group with which she lacked experience. She reported finding that

"The client I eventually took on was quite tricky because he had a background of learning disability, and I was worried about how this might affect his ability to understand the key concepts of CBT".

However, respondents also made reference to being supported through these challenges. Respondent J for example went on to say that

"(The supervisor) was excellent in guiding me through delivering CBT to my client in such a way that it was understandable and useful to (them)*".*

Improvements

Eight participants responded to the question asking for suggestions to improve the programme. Of these five stated that they did not feel any improvements were necessary. The remaining three respondents recommended five changes. There was no overlap in the recommendations between respondents.

Respondent F highlighted concerns about a **delay in starting programme**, stating,

"*We were told in induction by several people that we needed to get going ASAP and everyone was keen to get involved, but many of the formal introductory sessions didn't happen for a while"*.

This respondent also made two suggestions about how two improve the process. One relating to **access to cases**

"I think that some trainees are unfairly disadvantaged with regards to access to appropriate cases dependent on their first job and some extra support for them may be useful."

And one recommendation for **pre-training discussions with former trainees** who have already completed the programme.

"I think it would be helpful for new core trainees to have an organised session with CT2/3s so that they can be reassured and prepared for what to expect in the coming months."

Similarly, another respondent (K) suggested that the opportunity to undertake **pre-training observations of therapists** *"practicing CBT before starting a case would have been more beneficial than jumping straight in"*.

The final suggestion for improvement (from Respondent I) suggested that *"more* **(live supervision)** *recordings of the CBT sessions so I could listen and review these with my supervisor"* would be helpful.

Each of these is a valued suggestion about how to improve the service the trainees receive and will be addressed further in the discussion section.

Perceived benefits of programme and positive overall positive experience of training.

Overall, the programme appeared positively received, with six respondents making broad reference to positive overall experience of the training and five to specific benefits of the programme. Of the latter, four participants commented that the programme had enabled them to make **changes to their practice**. Respondent B, for example found said that

"I think it has improved my practice, as now I can refer a patient for CBT really understanding the process. I have also used some of the CBT techniques whilst assessing patients which have also been very helpful."

and four, such as respondent G, identified that their **skills had improved**.

"I… felt that (the CBT short case) *gave me additional communication skills when working with patients."*

Of those who made broader positive comments about their experience, five reported finding it **valuable**. Respondent D, for example reported finding the programme *"useful for specialisation of junior doctors into psychiatry".*

Three respondents reported finding the course **enjoyable** such as respondent G, who stated

"*I really enjoyed the CBT short case*"

and one (Respondent F) **compared it favourably with training received in other trusts**.

"I have several colleagues undertaking psychiatric training in other trusts who have really struggled with their short and long-cases and have felt adrift and unsupervised. I feel the quality of supervision now in place in our trust far exceeds the experiences of many of my peers."

Assessed outcomes SAPE and PACE

Nine of eleven respondents gave permission to use their assessed outcomes anonymously in the study. Because data from the ECTSQ were collected anonymously, at a different time to participants' end of case competency assessments it was not possible to analyse individual participants' responses in relation to their SAPE and PACE scores. However, all the participants successfully passed the training programme. On the SAPE, 32% of grades were 'satisfactory' and 68% 'accomplished'. On the PACE 29% of grades were 'satisfactory' and 61% 'good'. This averages to 31% 'satisfactory' grades and 69% 'good' or 'accomplished'.

Discussion

Evaluation of learning and assessed outcomes of the programme

The primary purposes of the Core Trainee CBT Programme are to enable the trainees to achieve the level of competence in CBT required to meet the learning objectives required by the RCPsych, and to enable them to progress to the next level of their training. Its secondary purpose is to enable trainees to learn appropriate CBT and psychotherapy skills, with which to enhance their clinical practice and develop as a psychotherapeutic psychiatrist. This evaluation suggests that the programme has met both of these objectives. All trainees who have attended the programme so far have successfully completed it, and outcomes from participating trainees suggest a high level of attainment. It should be noted however, that assessment of trainee competence was conducted by their supervisor, who is also the author of this thesis, so may be subject to bias. This is difficult to protect against as this assessment is part of the supervisor's role and there are no standardised assessments for trainees practicing at this level (see general discussions on assessment of competence in Chapters 1 and 6); also co-markers are not available to test for reliability. However, all trainees were discussed and reviewed with the psychotherapy tutor, and a rating guide was provided for use with the SAPE (see Appendix E) that was adhered to.

Responses to quantitative questions one to thirteen also indicate that participants not only valued their experience on the programme but also believed their knowledge and skills increased significantly during it. Once again, a caveat to this is not all (50%) of the trainees who have undertaken the programme participated in the evaluation, making it impossible to gauge the opinions of those who did not. It is also possible that respondents may have experienced a memory bias as they were asked to complete the evaluation in hindsight and, for some, this occurred a significant time after they completed the course.

Quality and Structure of Supervision and Training

All participants who responded to the qualitative component of the questionnaire made positive comments about the quality or structure of the teaching or supervision. These responses relate strongly to the established competency framework for supervision, as Roth and Pilling (2008a) identify that the ability to employ educational principles which enhance learning is a key component, not just of teaching but also supervision.

A number of respondents described the supervision process as supportive and conducive to experiential learning. The importance of this is identified in evidence from broader studies of psychotherapy supervisees' experiences. Allen et al. (1986) for example, in their survey of 142 counselling and psychology trainees reported finding that the degree of trust that trainees had in their supervisor, along with their perception of their supervisor's expertise, were far greater discriminators of a positive supervisee experience than supervisor experience, career background or sociability. They also reported finding that supervision that was focused toward trainees' personal growth was highly prized when compared to pure technical skills training. Similarly, Pretorious (2006) highlights the need to attend to supervisees affect, and cognitions about themselves and their practice, in supervision.

When working with Core trainees it was necessary to reassure them that a positive assessment of their progress was not necessarily dependent on their outcomes in therapy, rather the supervisor was looking for them to push themselves out of their comfort zones and try new ways of interacting with their service users in order to attain the requisite level of skill. Similarly, many trainees had to adapt to the psychotherapy supervision model, which required a great deal of self-reflection and problem based learning, and needed reassurance that they would not be penalised for trying to answer questions that they did not necessarily know the answer to. This focus on stretching beyond your core training was highlighted throughout the programme and relates to Awal's (2016) comments about the training of the "psychotherapeutic psychiatrist" being one of personal development as much as skills learning. The fact that the trainees felt supported to do this was reflected in the feedback related to the supervisory relationship. Quantitative ratings from Q13e, for example, concurred with qualitative data, indicating that the supervisory relationship was amongst the most valued and useful aspects of the programme. Whilst there was obviously an emphasis on interpersonal skills when developing this

relationship, it is worth noting that whilst the structural and process components of supervision are identified separately to supervision quality, these are also important contributors to the development of the supervisory alliance (Milne, 2009).

Self-Practice and Self-Reflection

As expected, this component of the training was highly valued, with median ratings of 9/10 in quality and importance, and 8/10 with regard to participants' ability to use their skills and knowledge personally. This suggests that overall respondents felt able to reflect on their learning and apply it to themselves and concurs with anecdotal evidence from the programme in which a number of trainees expressed that they had used the skills learning to help in their own lives.

It was surprising however, that so few respondents identified this component of the programme in the qualitative component of the evaluation. One possible explanation for this was a difficulty in implementing SPSR into the training in an explicit way. Whilst trainees were encouraged throughout the programme to reflect on their learning and skills development and to attempt to apply this to their own skills development, a hoped for structured SPSR programme proved difficult to implement. One possible reason for this was an expressed lack of time outside of the taught and supervised sessions by the trainees. Whilst this was not highlighted directly in the evaluation it was expressed by trainees on a number of occasions during the supervision process, and is highlighted as a common issue for psychiatry trainees undergoing specialist psychotherapy training (Argawal et al., 2007; Calabrese et al., 2015). Because of this, between session learning tended to focus primarily on developing skills and knowledge related to the direct treatment needs of the service users they were working with. When trainees were asked to engage in skills practice and reflection outside of their direct service user work, concordance was sporadic. Whilst it was not specifically highlighted by any of the respondents in this study, a lack of time to meet learning needs has been identified as an issue in another study of CT1 core psychotherapy training (Carson & Clark, 2017). An awareness that many of the trainees were struggling to find time to balance this with the other learning requirements of their training, including exam preparation, led to reluctance on the part of the trainer to impose further homework in the form of structured SPSR. Despite the lack of a formal SPSR programme however,

responses to Q12 indicate that supervisees generally believed that they were able to reflect on their learning and apply it to their own lives. The challenges related to introducing a structured SPSR programme into a clinical setting are discussed at length in Chapter 5 of this thesis.

Practical Work

One of the more surprising outcomes from the study was how little reference was made to the actual practical experience of conducting therapy with a service user. Whilst it was rated as important for knowledge and skills development (means 9.10/10 and 9.40/10 respectively) it was mentioned only briefly during the qualitative analysis. One reason for this might be that the participants believed that they were responding to questions specifically about the supervision and training they received, as there were no questions that asked them to directly consider their work with service users.

Comparison of perceived quality and importance of aspects of the programme.

All aspects of the training programme were rated very highly in terms of quality and importance to the learning process. In the comparative analysis, only one statistically significant difference was found; namely between the perceived quality of supervision and the quality of practical work undertaken. This could be a type one error resulting from the inflation of family-wise alpha due to multiple comparisons because it is no longer significant when multiple comparisons are controlled for (Clark-Carter, 1997). It is worth noting however, that a number of respondents highlighted difficulties with service user drop out and non-concordance as challenges to overcome in the programme. Whilst we cannot be certain that difficulty in finding suitable cases had a role in the lower rating of practical work it was mentioned as a particular issue by one respondent. It is also a frequently documented issue for core trainees in other services (Agarwal et al., 2007; Carson & Clark, 2017). This was a particular issue in the employing Trust, as the timing of the start of the short case often coincided with the start of first year Clinical Psychology trainee doctoral placements in the service. Clinical Psychology trainees are required to provide therapy for cases of a similar level of complexity to those seen by core trainees and may be prioritised by allocating psychologists, who have a specific responsibility for the development of trainees from their own professions. One possible solution is offered by Moorhead (2015) who evaluated the attachment of core psychiatry

trainees to an IAPT service that provided one to one CBT to individuals suffering from mild to moderate anxiety and depressive disorders in a primary care setting. Moorhead reported finding that; of the 11 trainees placed with the service 86% were allocated a suitable case within six months, in comparison with only 50% in the previous year (before the attachment). Of these cases just over 50% were able to achieve clinically significant outcomes, meeting the targets of the supporting service.

Whilst it is positive that all aspects of the training programme were rated so highly, the lack of significant difference in this section of the analysis is perhaps surprising given that the supervision component of the programme was longer, more intensive and better suited to meet the idiosyncratic needs of the learners. Additionally, drawing on Bennett-Levy's (2006) DPR model one might expect the taught components to be rated more highly with regard to knowledge learning and supervision to be rated more highly for skills development.

Challenges identified in the programme

The challenges that were identified in the evaluation fall broadly into two categories; challenges relating to service user identification and engagement (as discussed above), and challenges relating to trainee's lack of previous experience in CBT.

This second challenge was a particular issue when developing the training and supervision programme. As discussed in the introduction, CBT training tends to conform to one of two formats; full psychotherapist training, which tends to take place over at least one year's full time study, or CBT interventions (or low intensity) training, which is shorter. Due to the nature of the competencies that psychiatry trainees are required to display (Royal College of Psychiatrists, 2015), trainees are required to conduct psychotherapy of an intensity and depth equivalent to a psychotherapy case, which would normally require a much greater degree of training than is available to them in the taught component of the programme. To compensate for this, the education component of supervision was particularly important in the development of theoretical understanding, as well as skills training and reflection.

Developments to training provision resulting from the evaluation and future recommendations

Identification of suitable cases/Opportunities for shadowing experienced therapists

Difficulties identifying and engaging with service users who had an appropriate level of need was frequently highlighted as a challenge in the evaluation, with **Service user non-attendance/Drop out** being identified as a challenge by three participants and **Service user non completion of homework** by one. As a result, Moorhead's (2015) IAPT placement model was implemented by the Trust. This allows for fast identification and allocation of clinical cases (the Trust IAPT service receives over 13,000 referrals and self-referrals per year). Such links also provide a greater opportunity for trainees to shadow qualified CBT therapists prior to starting their case. The model requires minimal input of resources from the host IAPT service, as supervision continues to be provided by the supervisor on behalf of medical education department and benefits the host service in terms of increasing the number of service users seen.

Organised sessions with trainees who had previously completed the course.

One suggested improvement to the course was to provide trainees with the opportunity to discuss their expectations with others who have already completed the programme. Core trainees' currently have access to senior trainees through general working practice and a senior trainee is now invited to speak to new CT1s about their experiences, during their induction. It is recommended however, that one or more trainees from the previous year's cohort be invited to speak to the trainees at the start of the CBT training programme, in order to answer questions from a participant perspective, and offer support and reassurance to the new starters. This can be organised by the supervisor/trainer with the agreement of the department.

Limitations

A number of limitations of the study were identified. The first was that this evaluation was carried out by the CBT supervisor and developer of the training and supervision programme, giving rise to a large amount of potential experimenter bias. Similarly, the author also conducted end of programme assessments of trainee competence (SAPE and PACE) for the trainee's RCPsych portfolios, which are referenced within the evaluation. It is also possible that trainees who had a positive experience on the programme, or who had formed a positive supervisory relationship with the author would be more likely to respond to requests to participate in the evaluation, skewing the data in

a positive direction. Whilst this limitation is potentially profound, it has the greatest bearing on the relationship between the training and assessment of the trainees, in which the individual responsible for training and supervision (the author) is also responsible for passing or failing them at the end of the programme. It could be argued that this is a limitation of the training programme requirements, as set up by the hosting Trust and Deanery, as opposed to the evaluation itself however and the fact that it is addressed in herein as a limitation of the programme demonstrates the benefit of the evaluation itself. The secondary question of potential biases in participant reporting and data collection were addressed where possible. All participants on the training programme were approached for feedback, regardless of their perceived relationship with the supervisor, and confidentiality was maintained through the recruitment of a third party, who received and anonymised responses before passing them on for the purposes of evaluation. Finally, all participants had already completed the training programme before being approached, some several years before the evaluation was carried out, and many worked for other Trusts. As such there was no pressure to provide positive responses for fear of affecting their grades.

Another limitation of the study was in the data collection process. Had the evaluation been planned from the start of the programme, as opposed to post hoc, some data on trainees' perception of their competence could have been collected before the programme began, enabling this to be compared with post hoc hindsight data. This would also have enabled analysis of the Dunning Kruger effect that leads inexperienced practitioners to over rate their competence prior to training, as comparison between pre training, and post hoc evaluation of competence would be possible. This method would also have allowed data to be collected from participants at a standardised time after they completed the programme (three months post case for example). Another learning point of this study is that it would also have been appropriate to request access to portfolio assessment data at the same time as the ECTSQ evaluations were sent out. This may have increased the response rate to this request and would have allowed a more detailed analysis of participant experience in relation to their end of programme competency. The generalisability of evaluation findings should also not be

overestimated. Whilst the results of this study add to the existing literature and concord with many of the themes identified in previous research (Carley & Mitchison, 2006; Hwang & Drummond, 1996; Podlejska-Eyres & Stern, 2003), it should be noted that this is an evaluation of a single training programme, and it results should not be generalised beyond this.

From a research perspective it would be ideal to have conducted a randomised control trial in order to investigate any causal relationship between the training and changes in perceived competence but that was not possible given the service requirements that the programme was designed to meet. In particular it would not have been ethical, in terms of duty of care to either service users or trainees, to utilise a control group to conduct therapy without training.

Conclusion

This evaluation adds to the limited cache of investigations into psychotherapy training for psychiatry trainees. The results suggest that a training and supervision programme developed from current, evidence based practice in the training and supervision of CBT psychotherapists can meet the needs of core psychiatry trainees' short case psychotherapy training. It also suggests that such a programme has been generally well received by those who participated in the evaluation, and that participants were able to develop skills and knowledge in CBT practice appropriate to their position and level of training, aiding in their development as a psychotherapeutic psychiatrist. Challenges encountered by participants have been addressed and changes to the programme have been made based on feedback.

Chapter 5

Critical reflection on a Structured Self Development Programme and its applicability to an experienced CBT therapist.

Introduction

Reference to self

Given the first person reflective nature of this account I will be using the term "I" (rather than "the author") to refer to myself throughout.

Context

This paper is an autobiographical account of the process of undertaking a CBT focused self-development programme, written from the perspective of an experienced CBT Psychotherapist with over ten years' experience training, supervising, and practicing CBT. I currently work as Clinical Lead in an NHS primary care IAPT Service that provides short term (6-12) session CBT to people with mild to severe anxiety, depressive and integrated health problems. My primary role is the clinical leadership of the service, maintaining ethical standards and best practice but I hold a small clinical caseload. I also have experience as an education manager for the host Trust, with responsibilities for organisation and facilitation of training programmes in CBT and wider psychotherapies, and retain some aspects of these responsibilities in my current role.

This study is a critical reflection on my experience undertaking a form of CPD in CBT, known as Self Practice and Self Reflection (SPSR) (Bennett Levy et al., 2001). This process is akin in some respects to therapists attending their own therapy, something that is not compulsory for the UK training of CBT Therapists (British Association for Behavioural and Cognitive Psychotherapies, 2017). However, rather than attending therapy with another professional, SPSR provides a framework for enabling the therapists to apply their therapy skills to themselves for personal and professional development, using a guided self-help model. I first became aware of SPSR through a teaching role

and as the individual responsible for maintaining best practice in the service I was considering using a programme in our service for the following reasons;

- Maintenance of clinical standards in the team as a whole
- Recovery of clinical standards for therapists who were finding it difficult to meet their recovery targets over a prolonged period.
- As a form of Continuing Practice Development for the Team
- As an opportunity to allow therapists to engage in a personal wellbeing orientated experience.

I decided to explore the experience of working through an evidence based, structured SPSR self-development programme based on the book "*Experiencing CBT from the Inside Out: A Self Practice/Self Reflection Workbook for Therapists"* (Bennett-Levy et al., 2014) (Inside Out) focusing both on my role as a therapist and as clinical lead for a primary care psychological therapy team.

Therapist effects in psychotherapy

As part of my role, it is my responsibility to ensure that the service provides effective, evidence based treatments to those who use our services. This involves reviewing best practice in the field (in terms of effective treatment and training) and ensuring that therapists remain up to date and maintain their skills.

Research on the degree to which differences between therapists can affect therapy outcomes gives a range of results. A number of studies estimate this variance to be the region of 8-17% (Crits-Christoph et al., 1991; Lutz et al., 2007), depending on measures and analysis. The factors associated with the relationship between therapist difference and client outcomes are many. These include therapist experience (Crits-Christoph et al., 1991); adherence to an evidence based model or use of a manual ((Crits-Christoph et al., 1991; Waller, 2009); and the therapeutic relationship (Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000), of which therapeutic empathy is a core component (Feller & Cottone, 2003; Greenberg, 2007).

Psychotherapists and their own psychotherapy

One model that has been suggested, in wider psychotherapy, to improve therapist competence, is that of therapists attending psychotherapy from the client perspective. SPSR has been described as the process of therapists using their own skills on themselves, in some ways mirroring this process. The benefits or otherwise inherent in psychotherapists undergoing their own psychotherapy have long been debated (Greenberg & Staller, 1981) though, and opinions vary depending on the modality of therapy being undertaken, or whether the therapist being asked has actually undergone the process (Norcross, 2005). Therapists in favour highlight the importance for therapist wellbeing and positive impact on therapist experience as key factors (Macran & Shapiro, 1998). Posited benefits to therapy competence range from the practical (i.e. it being important to prevent the therapists own issues from interfering in therapy) at one end of the spectrum, to it being a part of the very identity of the psychotherapist at the other (Greenberg & Staller 1981; Norcross, 2005). It can also be seen as a useful process in helping trainee and newly qualified therapists to experience what therapy is like from the perspective of a client, and to observe it being practiced by a more experienced therapist. Research into the actual relationship between therapists attending their own therapy and client outcomes is limited however (Beutler et al. 2004). In their (1998) review of literature in the area Macran and Shapiro noted that the majority of research was based on therapist questionnaires rather than client outcomes, but that there was some evidence that therapist factors such as empathy, genuineness, and warmth, all of which are identified as key factors in effective CBT (Blackburn et al., 2001), may be affected. Earlier meta-analysis by Greenberg and Staller (1981) however, found that of eight studies looking into the relationship between therapist personal therapy and outcomes for their clients only two "hint" at a positive effect, four showed no discernible relationship and two actually suggested that there may be a negative relationship. This review is not focused on the experiences of CBT psychotherapists however. Additionally, as discussed in Chapter 1, therapy outcomes are not the only (or necessarily the most valuable) measure of therapist competence. As such, whilst the need for CBT therapists to undergo their own therapy is far from evidenced there is a body of opinion that they benefit from developing self-knowledge and awareness

(Bennett- Levy, 2006; Bennett-Levy et al., 2015; Safran & Segal, 1990). Unlike some other psychological therapies however (UK Council for Psychotherapy, 2021), there is little emphasis on this in CBT psychotherapist training, and neither trainee nor accredited CBT therapists are required to undertake any CBT or other psychotherapy sessions from the client perspective (British Association for Behavioural and Cognitive Psychotherapies, 2017; British Association for Behavioural and Cognitive Psychotherapies, 2018).

There are a number of reasons why this lack of focus on psychological self-development may be a particular issue in CBT. Training to the level of accredited Cognitive Behavioural Psychotherapist in the UK requires a minimum of 450 hours of specialist teaching and a minimum of 200 hours of supervised clinical practice (British Association for Behavioural and Cognitive Psychotherapies, 2017), all of which is usually completed over the course of a post graduate diploma taking a single academic year. Over a number of years teaching and supervising trainees studying for CBT Postgraduate Diplomas, I have observed that the short duration of these courses can leave trainees struggling to learn and practice the wide range of therapeutic skills necessary to become a reflective therapist. I have also noticed that this difficulty can continue after accreditation, particularly in highly pressured services such as IAPT, where therapists, who can see upwards of six clients a day, have reported to me that they find it difficult to find time to reflect on their practice. This lack of opportunity for reflection is potentially exacerbated by a second issue, namely a focus in CBT (and consequently therapist training) on prescribed, evidence based protocols and treatments. Whilst evidence based treatments are considered the gold standard in CBT, it has been argued that such practices can result in an over reliance on technical competence at the expense of the personal development of the psychotherapist (Norcross, 2005). This can lead to a risk of inflexibility and to what Kuyken et al. (2009) describe as a “Procrustean Dilemma”, an over reliance on one size fits all treatment protocols, over flexibility and responsiveness to individual difference.

Self-Practice and Self Reflection

One model developed to try to address the lack of self-reflection in CBT training is that of Self Practice and Self Reflection (SPSR) (Bennett-Levy et al., 2001). SPSR is comprised of two similar, concepts that fulfil slightly different roles in therapist development. Self-Practice (SP), being the act of practicing therapy skills on oneself, in order to better understand the processes, has long been a recommended method of better understanding the processes of CBT (Beck & Beck, 1995; Greenberg & Padesky, 1996), and is likely to include practical tasks utilised in CBT with clients. This can include activities such as completion of behavioural experiments or graded exposure techniques as well as the use of tools including questionnaires, activity diaries and therapy records (Bennett-Levy et al., 2001). SP fulfils a number of purposes, it allows the therapist to experience the process of using CBT tools and techniques directly, unearthing potential roadblocks and highlighting benefits that they may not have recognised through a purely academic process of learning. Secondly it allows the opportunity to practice therapy tools and techniques on a willing subject (themselves), allowing the therapist to retry things when blocks are encountered. The Process of Self Reflection (SR) by contrast involves reflecting on and analysing both the SP process, and one's own perspectives, prejudices and beliefs as a means of further developing reflective and reflexive skills (Bennett-Levy et al., 2001; Bennett-Levy et al., 2015).

In addition to focusing on therapist's skill development, Bennett-Levy et al. (2015) claim that SPSR can also be used to help therapists focus on non-therapy related personal development, in much the same way as attending psychotherapy with another therapist. If this is true then SPSR can potentially fulfil a second effect of therapists attending their own psychotherapy, that of improving their own personal wellbeing.

SPSR evidence

Evidence for the effectiveness of SPSR in improving therapist skill is building (Gale & Schroder, 2014 ; Laireiter & Willutzki, 2003), but like that relating to therapists attending their own psychotherapy, focuses primarily on therapist experience rather than client outcome (Laireiter & Willutzki, 2003).

However, studies of therapist attitude and opinion identify a range of perceived benefits to SPSR (Gale & Schroder, 2014), for a range of therapist groups within the CBT milieu, including Low Intensity Psychological Wellbeing Practitioners (PWPs) (Thwaites et al., 2001; Bennett-Levy et al., 2003; Thwaites et al., 2017), Clinical Psychology trainees (Bennett-Levy et.al., 2001) and experienced CBT therapists (Davies, et al., 2014). The act of going through the CBT focused techniques in the programme were linked with a range of therapist factors, including perceived improvements in therapist skill (Bennett-Levy et al., 2003; Davies et al., 2014; Thwaites et al., 2015), increased understanding, of and ability to explain the CBT model (Bennett-Levy et al., 2003), increased attention to the therapeutic relationship (Bennett-Levy et al., 2003), and improved reflection and flexibility to client need (Bennett-Levy et al., 2001; Bennett-Levy et al., 2003). A number of studies also identified an increase in the recognition of the challenges of therapy for clients, especially in the context of non-engagement, and with feelings of increased empathy and ability to place oneself in the client's shoes (Bennett-Levy et al., 2001; Bennett-Levy et al., 2003; Davies et al., 2014; Thwaites et al., 2017). There was also evidence that participating in SPSR related to changes in beliefs about both the personal and professional self (Thwaites et al., 2015), adding to evidence that it could mirror the process of individual therapy for therapists. Implementation of SPSR is not without its challenges, however. Concerns such as fear of judgement, invasion of privacy and worries about becoming overwhelmed by emotions whilst undertaking the programme have been identified by CBT therapists and Psychological Wellbeing Practitioners as concerns about engaging in SPSR programmes (Haarhoff et al., 2015).

There are two apparent limitations to the studies conducted into SPSR at the time of writing however. First, the lack of client outcome focused studies means that evidence that the process has relevance to the people that the therapist sees rather than just to the therapist themselves is limited. Secondly a considerable proportion of the research into SPSR has been conducted with the collaboration of the intervention designers (primarily Bennett-Levy, Thwaites and Freeston). As such experimenter bias needs to be accounted for. However, studies do consistently indicate that SPSR can contribute to the learning and development of CBT therapists and psychologists with a range of levels

of experience, particularly in the area of empathic development. Rather than simply add to the existing evidence in a similar way, this study seeks to explore the experience of a single experienced CBT therapist (myself). Whilst these observations will touch on my learning and development experiences, they will also take a more practical approach, exploring the stresses and time commitments of undertaking such a programme, with a view to evaluating its appropriateness as an on ongoing therapist development approach in a busy Primary Care IAPT service.

Setting

The setting for the study was an NHS Primary Care IAPT Service. The service is unusual in that it was contracted under the "Any Qualified Provider" (Department of Health, 2011) purchasing system, in which services are funded using a payment by activity contract, with payments made for each treatment completed by the team. This is relevant as any time taken away from client contact for therapist development costs the service significant revenue and must therefore be justified and balanced alongside financial implications for the team.

The Programme

The study utilises the CBT SPSR programme "Experiencing CBT from the Inside Out" (Bennett-Levy et al., 2015), a twelve section modular programme that draws on core trans diagnostic cognitive and behavioural techniques, as well as culturally responsive and strength based CBT formulation models. The stated aim of the programme is to provide a "structured experience of using CBT on themselves (SP) and reflecting on the experience (SR)" (Bennett-Levy et al., 2015, p.1). Whilst being based primarily on the core CBT techniques developed by Beck et al. (1979) the programme also addresses both strength based CBT Techniques (Padesky & Mooney, 2012), observation of cognitive processes, such as metacognition (Wells & Leahy, 1998) and selective attention (Harvey et al., 2004).

The twelve chapters of the programme can be viewed in three broad categories;

1. Assessment, formulation and goal setting

2. Descriptive and maintenance level interventions and techniques
3. Deeper schema level processing and change.

Assessing, formulation and goal setting

Initial modules utilise existing CBT techniques to assist the participant in developing two core problem statements to work on over the course of the programme. These are then used to develop SMART goals (Doran, 1981) and to guide the participant to formulate their identified difficulty from problem and strength focused perspectives. The process of formulation (or Case Conceptualisation) has been described as "a coherent set of explanatory inferences about the factors causing and maintaining a person's presenting problems" (Bieling & Kuyken, 2003, p.53). Whilst the evidence base for formulation based therapy is limited (Bieling & Kuyken, 2003; Kuyken, Padesky & Dudley, 2008) it is regarded, by many as a key aspect of CBT practice (Blackburn et al., 2001; Kuyken et al., 2011).

Descriptive and maintenance level interventions and techniques

The second section focuses on change methods. The participant is guided through change components of the programme, utilising core CBT techniques such as thought records, behavioural activation and behavioural experiments to test out assumptions they may have held about the area of change and develop new ways of addressing them. This section utilises a structure frequently recommended in CBT formulation and treatment (Greenberger & Padesky 1995; Kuyken, Padesky & Dudley, 2011). This begins by working on the behavioural and situational aspects of the problem using CBT techniques, that the participant should be used to practicing with clients, such as behavioural activation (Dimidjian et al., 2014) and cognitive restructuring (Beck et al., 1974).

Deeper schema level processing and change

The programme then goes on to address deeper level processing by exploring the rules and assumptions (Beck et at., 1979) by which we live our lives in order to facilitate long term change. These rules and assumptions (alongside the most basic of cognitive processes Core Beliefs (Beck et

al., 1979)) make up what are sometimes known as “schema”; core, stable structures or frameworks for understanding the world and our place in it (Beck et al., 1979). Such schema can serve a number of purposes and can be both helpful and unhelpful in supporting good mental health. In order to do this the programme makes use of a new approach known as the “New Ways of Being” model (p.11). This involves the development and practice of alternative positive ways of viewing yourself and the world as a way of overriding older, less helpful schema.

Method

Study Design

My reasons for undertaking this study were twofold. First, the aim of this thesis is to explore the practical applications of CBT research for the development of CBT services. Whilst the evidence for SPSR as a form of CPD in improving therapist skills, particularly in the field of empathy for the client experience, in order for the model to be of use in a practical setting it has to be possible to complete it in a reasonable amount of time, without dramatically adding to the workload and stress levels of participants. Prior to this study I used the Inside Out manual as a basis for supervision of a clinician in my service, who was struggling to maintain her clinical outcomes. This culminated in considerable improvements to the quality of the therapy she carried out, both in terms of her quantitative outcomes and the qualitative feedback that she offered. She described the process as challenging but said that it had helped her to refocus on both the structure of her therapy and her engagement with clients. However, she also described feelings of exposure and vulnerability whilst undertaking the programme. She also required time out of clinical practice in order to complete it, placing a cost burden on our service that was paid by activity. Whilst this had been a positive experience overall, and met its goals for this member of staff, I was left unsure as to whether it would be as helpful in a wider context for the team, either as a service wide tool, or a focused one for use with clinicians who were struggling. As a follow up I wanted to gain personal experience of the Inside Out programme, in order to assess its utility as a staff training and wellbeing tool in the service that I lead. In order to review my experiences, I used a Reflective Topical Autobiographical (Johnstone, 1999) (RTA)

design, effectively utilising myself as the single subject of an n=1 exploratory (Yin, 2018) case study. This model of investigation is based in the interpretivist ontology, which was necessary as I was seeking to develop an understanding of my experiences beyond that of the purely objective. Approaching the study from this perspective enabled me to reflect on my overall experiences of the programme, putting them in the historical and social context of my upbringing, and prior training and experiences as a psychotherapist (Crotty, 2010). This interpretivist approach gelled particularly well with the autobiographical design, as it lends itself to recognition of the perspective of the participant (Chetty, 2013). Criticism has been made of case study designs, and in particular single subject case studies for an over emphasis on interpretation and a lack of generalisability of their findings (Idowu, 2016; Stake, 1995; Woodside, & Wilson, 2003). Stake (1995) however, refutes this, arguing first that all content involves generalisation and interpretation of some sort, and latterly that by looking at a subject in more depth it is possible to refine pre-existing broader generalisations, a method common in research of all types. Whilst it is not possible or appropriate to make broad generalisations from this method, one of the strengths of the case study approach is its ability to explore experience and theory, both in depth and in a real world context (Yinn, 2018). By referring to the broader literature throughout I have attempted to link my experiences to those described in other studies in order that the interpretations or assertions (Erickson, 2012), may be constructed within and seen as part of the greater whole, rather than in isolation. The question of subjectivity is especially relevant to an autobiographical study and does not necessarily have to been seen as a detriment. As Johnstone (1996) describes, rather than striving for objectivity, the RTA approach should focus on

i. *increasing understanding of subjectivity and making subjective experiences more visible and intelligible* (and)

ii. *the search for meaning and increasing understanding of the commonality of existential human experience and decentring the detached observer.* (Johnston, 1996, p.24)

It was not my intent in writing this paper to review the efficacy of the Inside Out SPSR programme itself as this has been done on multiple occasions in the past, and the single subject design offers little in this context. Rather my aim was to explore my experience of undertaking the programme, to assist in my considerations regarding its utility as a tool to be used in my clinical team.

An autobiographical stance allowed me to explore the lived experience of undertaking the SPSR programme in as broad a way as possible. It quickly became clear however, that both the autobiographical methodology and my experience and knowledge of the subject matter, meant that it was not possible to separate my prior knowledge or judgements from my experiences during the study (McConnell-Henry, Chapman & Francis, 2009). As such I drew on Heidegger's (1962) phenomenological approach, so that I might recognise the role that my history with, and expertise in the subject plays in my experience, rather than attempt to separate myself as researcher from my role as participant. In this way, embracing the subjectivity of my experience it was possible to make it part of the object of the study as a whole (Hamel, Dufour & Fortin, 1993).

As a reflective programme Inside Out requires a large degree of self-reflection, which I reviewed for patterns and themes. In order to gain multiple perspectives on the problem I also examined a number of other metrics, such as how much time I was able to dedicate to the programme within my working week, how busy I was and whether my confidence in my practice as a therapist and leader changed.

In critically analysing my own experience I hoped to answer the following study questions:

i. Does undertaking the programme of SPSR have a noticeable impact on my perceived wellbeing as a CBT therapist in an NHS IAPT service?
ii. What are my key learning experiences as a therapist undertaking the study and how do these affect my opinions and beliefs about CBT as a Therapy.
iii. What are the time and effort commitments of undertaking such a programme and is it feasible for CBT Therapists to undertake it in a busy "payment by results" service?

Measures

Content analysis of Reflective logs

The Inside Out programme requires reflective logs to be completed, based on a number of module specific questions. Reflections on the process were gathered from these, supplementary personal diary accounts and personal recollection. I attempted to pay particular attention to the emotional experience of completing the programme, as well as more cognitive reflections. This was in part due to an awareness of my own propensity to intellectualise in reflection but also due to an understanding that the analysis of feelings can be an important link between the intellectual pursuit of the research and the identity of the researcher as an individual (Heen, 2005). This is particularly important in the context of this study as the analysis of emotions is key in both the CBT and SPSR processes. Content analysis was carried out on the reflective logs using the process suggested by Stemler (2001).

Self-report scales

Busyness, stress and time spent on SPSR. Whilst I could see the potential benefit in the Inside Out programme, I was concerned about the time that it was likely to take (up to 30 hours) and how to prioritise this into my week. I was also concerned that in adding to my workload it might result in increased stress at work. Given this, I chose to record weekly measures of time undertaken doing SPSR and my own stress and busyness at work.

In order to measure stress, I adapted Littman et al.'s (2006) two single item measures of psychological stress. These self-report questions measure both perceived stress and ability to cope, as follows;

1. "On a scale of 1 to 6, how would you rate your ability to handle stress?" (from 1 for "I can shake off stress" to 6 for "stress eats away at me").
2. "In the past year, how would you rate the amount of stress in your life (at home and at work)?" (from 1 for "no stress" to 6 for "extreme stress")

Littman et al.'s second question, originally designed to assess perceived stress over "the past year" "at work and home" (p.398) was adapted to a shorter time frame of a week to allow greater sensitivity to short term stressors and references to stress in home life were removed. This left the question

2. "In the past week, how would you rate the amount of stress in your life at work?" (from 1 for "no stress" to 6 for "extreme stress").

Perceived busyness at work was recorded on a similar 1-6 scale for clarity of reporting with 1 representing “not busy at all” and 6 “extremely busy”.

Confidence Scales. The final measures were included to assess whether there was any change in my perception of my capabilities as both a therapist and leader. Given that much of the evidence for SPSR revolves around participants’ own perception of their own skills (Bennett-Levy, Lee, Travers, Pohlman & Hamernik, 2003), I wanted to explore whether there was any relationship between conducting the programme and my confidence as a therapist. To facilitate this, the Cognitive Therapy Scale-Self Reflection Scales (CTS-SR) (Bennett-Levy personal correspondence) was used at the start and end of the programme. This self-report scale was designed by adapting twelve areas of CBT competency developed in the Cognitive Therapy Scale – Revised (CTS-R) (Blackburn et al., 2001). The participant is asked to self-rate their competence on a scale of one to ten in a range of CBT related competences, with 1 being no skill, and 10 being master. They are also asked to rate their overall confidence in their therapy skills at the time of completion and to project their expected level of skill five years from then (see Findings and Discussion for full questionnaire).

I also included simple 1-6 scales of “confidence: leadership” and “confidence: therapy”, where 1 indicated very low confidence and 6 indicated very high confidence in order to investigate any ongoing relationship between undertaking the programme and my confidence in my therapy and leadership as the programme progressed.

Findings and Discussion

Reflective Log Content Analysis

In order to better understand the small data set, comments were broken down into propositional units so that their underlying meaning could be identified. Initial categories were agreed between two professionals using emergent coding and scored by both independently as suggested by

Stemler (2001). Initial inter reliability was low (75.409%) so the category definitions were refined and the logs were re scored. Inter-rater reliability was found to be 100% following this process. 10 propositional categories were identified through content analysis. These could be further categorised into five core concepts or experiences that I had going through the programme (see Table. 1)

Table. 1

Frequency of codes used and super-categorisation

Category	frequency	Super-category
Improved Client Understanding or Empathy	6	Insights or perceived improvements in CBT skills
Improved Therapy Techniques	30	
Helpful Practical Learning, not directly related to clients or CBT	31	Helpful learning or insight about myself
Reflections about myself	16	
Motivation	3	Motivation
Difficulty engaging in or resistance to SPSR	23	Difficult or aversive aspects of the programme
Avoidance of SPSR tasks	6	
Physical Aversion	5	
Easy/Not helpful	8	Reflections on where the programme was not as helpful as it could have been.
General learning rather than Goal specific	3	

In order to explore my experiences, I drew on these factors and the psychometric self-report measures used, to consider what was helpful and less helpful about the programme. In doing so however, it became clear that it was necessary to draw on the wider literature to give depth to this reflection. For this reason, it was appropriate to combine these findings with a broader discussion. As

such the following section takes the form of a narrative discussion of the process of undertaking the programme, whilst highlighting what was more or less helpful in my personal experience.

What I found helpful and less helpful about the programme

In order to explore the programme, reflective diaries and self-report measures were reviewed, and my experiences were ordered in terms of what was more or less helpful in undertaking my programme goals and the study questions, which are reviewed latterly in this section. Given the complex nature of the reflection, allocation of as subjects to either "helpful" or "unhelpful" was an overall judgement rather than an absolute one. As such balanced commentary is given for each subject as it appears.

Aspects of the programme that were helpful

Motivation

"It was not anxiety provoking to do, but I felt some excitement" (Reflective logs, p.184)

Whilst it would not be accurate to say that I enjoyed undertaking the programme as a whole, there was an element of enthusiasm that was captured in the logs at times. In particular this seemed to be linked to the anticipation of trying new things. This was surprising on reviewing the logs as the programme was difficult to complete but the exploratory nature of the experiments in particular, helped provide motivation to complete the programme.

Insights or perceived improvements in CBT skills

Undertaking the SPSR programme has helped me learn about or gain insight into my practice in three main areas. First the initial process of formulation and goal setting helped me to identify areas of my practice that I had not recognised as needing attention. Secondly the process of attending to my therapy practice was instrumental in enabling me to address a process known as therapist drift (Waller, 2009), which can lead to even experienced therapists drifting into bad habits and away from

best practice. Finally the programme enabled me to reflect and build on my relationship with clients, developing a greater understanding and empathy for their experiences.

Formulation and Goal setting. Early modules in the programme start the process of addressing therapist drift, by helping the participant reflect on areas of practice (or other personal issues) that they might want to address through SPSR. One of my main concerns was around the effect that reducing my clinical hours (as a result of my leadership role) was potentially having on my clinical practice, and whether this was negatively affecting both my work with clients and my supervision and consultation skills.

"I worry that as I no longer do as much therapy as I once did my skills are becoming "loose", particularly around structure and CBT specific skills." (Challenging problem description p.45)

The programme prompts the participant to use both problem focused, and strength focused (Padesky & Mooney, 2012) formulation models to explore these issues, and develop problem statements, a form of narrative formulation, to describe them. I found the strength based formulation particularly interesting. Completing this helped me to focus on the compassion that I have for my patients, as well as reminding me that I had the skills and knowledge I needed to fulfil my role. This helped me to feel more confident in my ability at an early stage.

"I was surprised how clearly it came together. The alternative (strength based) *formulation made me feel more confident"* (Reflective logs, p.76)

This problem statement was then used as a focus for the development of SMART goals (Doran, 1981) to work towards. This process differed somewhat from therapy, where this is a collaborative process of exploration between the client and therapist. However, in SPSR where the client and therapist are the same, the process lacks the multi perspective view which comes from a collaborative process. As such I relied on additional psychometric reports to aid in the process of self-formulation. My use of the CTS-SR scale (additionally to the Inside Out programme) was particularly helpful in identifying several core issues where I thought my therapy had drifted from best practice.

Whilst a range of therapist approaches and skills are present in successful therapy (Blackburn et al., 2001), it is possible to over rely on some at the expense of others. I felt that I had come to rely overly on reflective and listening skills, which had led to my becoming more passive in therapy than was ideal for a truly collaborative process.

I identified the following Challenging Problems or Situations

- Structure in CBT Sessions
- Homework setting and review
- Attending to evidence based protocols for treatment
- Eliciting Feedback
- Pacing and efficiency
- Lack of current experience is resulting in a lack of confidence.

This last point was of particular note in that it was a problem that arose from my seniority in the service. As the Clinical Lead, the majority of my time is taken up with management and leadership tasks, leaving only a little time for my own clinical practice. This led to a significant amount of imposter syndrome (Clance & Imes, 1978), in which I felt that despite my historic experience, my reduced current practice limited my ability to support and supervise others.

I identified my problem statement as follows

"My challenging problem: Worries and anxieties about my lack of current competence, as a result of limited CBT time is leading me to steer away from evidence based work towards a more ad hoc generic reflective stance as well as a more didactic one. As a result, I worry that my therapy is becoming less CBT specific and therefore diluted in efficacy. Specifically, I am aware that my attention to pacing and structure in the session is reduced, my sessions are longer than recommended and I am not planning sessions as thoroughly as I have in the past. As a result, my use of change methods is poor at times." (p.64)

From this I identified the following goals;

1. Increase Structure in therapy
2. Develop use of change methods in therapy

This approach of assessment, formulation, goal setting and intervention was helpful in that it mirrored the most common structure used in CBT (Beck & Beck, 1994). This made it easy for me to apply my prior knowledge of the therapy to the learning process (Knowles, 2014), and acted as a refresher in terms of re-establishing structure in my therapy sessions. A number of formulation techniques were employed to do this but those most helpful to me were the two five part formulations (Greenberger& Padesky, 1995), one problem focused, and the other strength focused; and a visual analogue scale (Bennett-Levy et al., 2014, p.48). These are shown in figures 1-3 below.

Figure 1

Five part formulation of issues in therapy

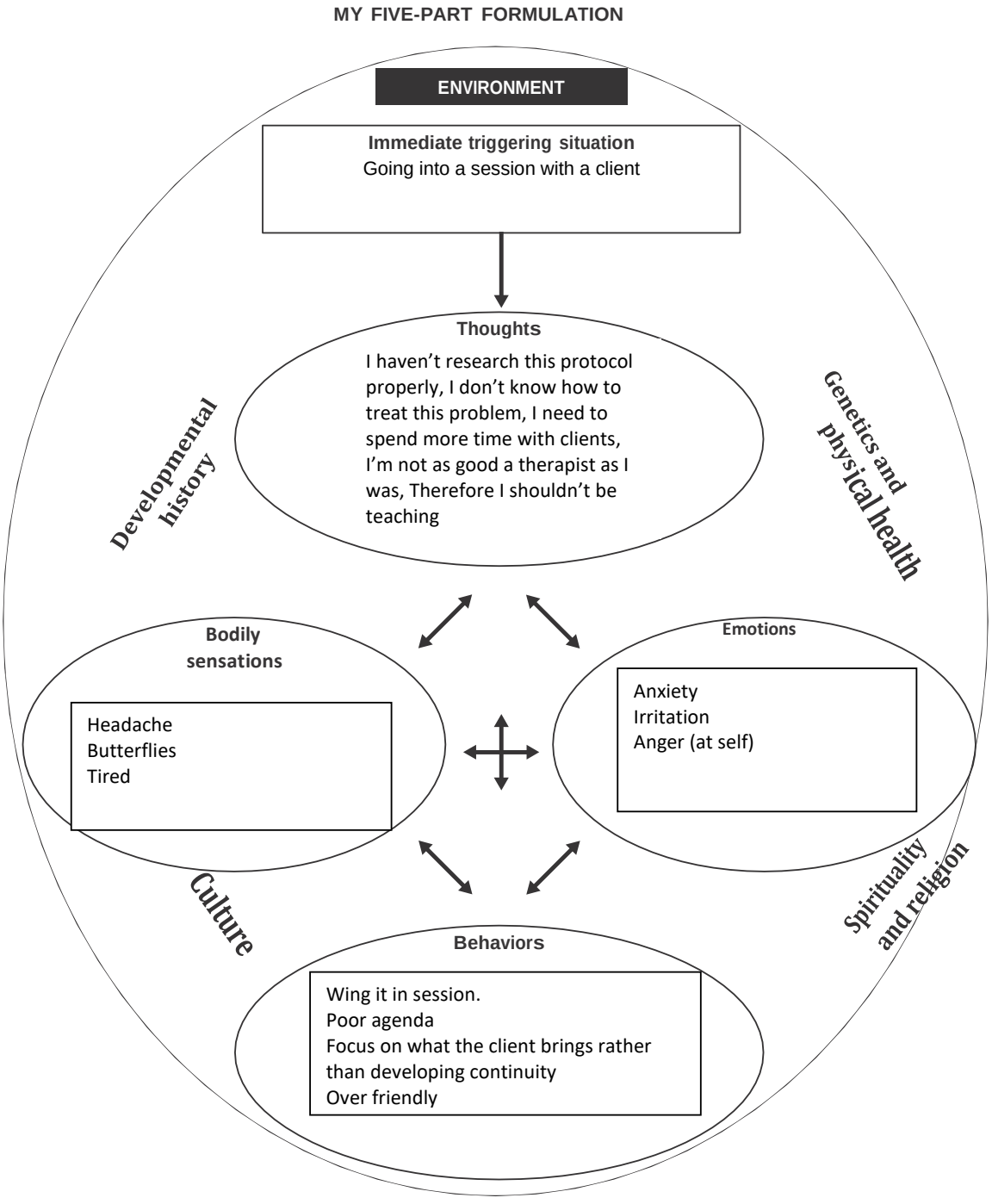


Figure 2

Five part strength based formulation

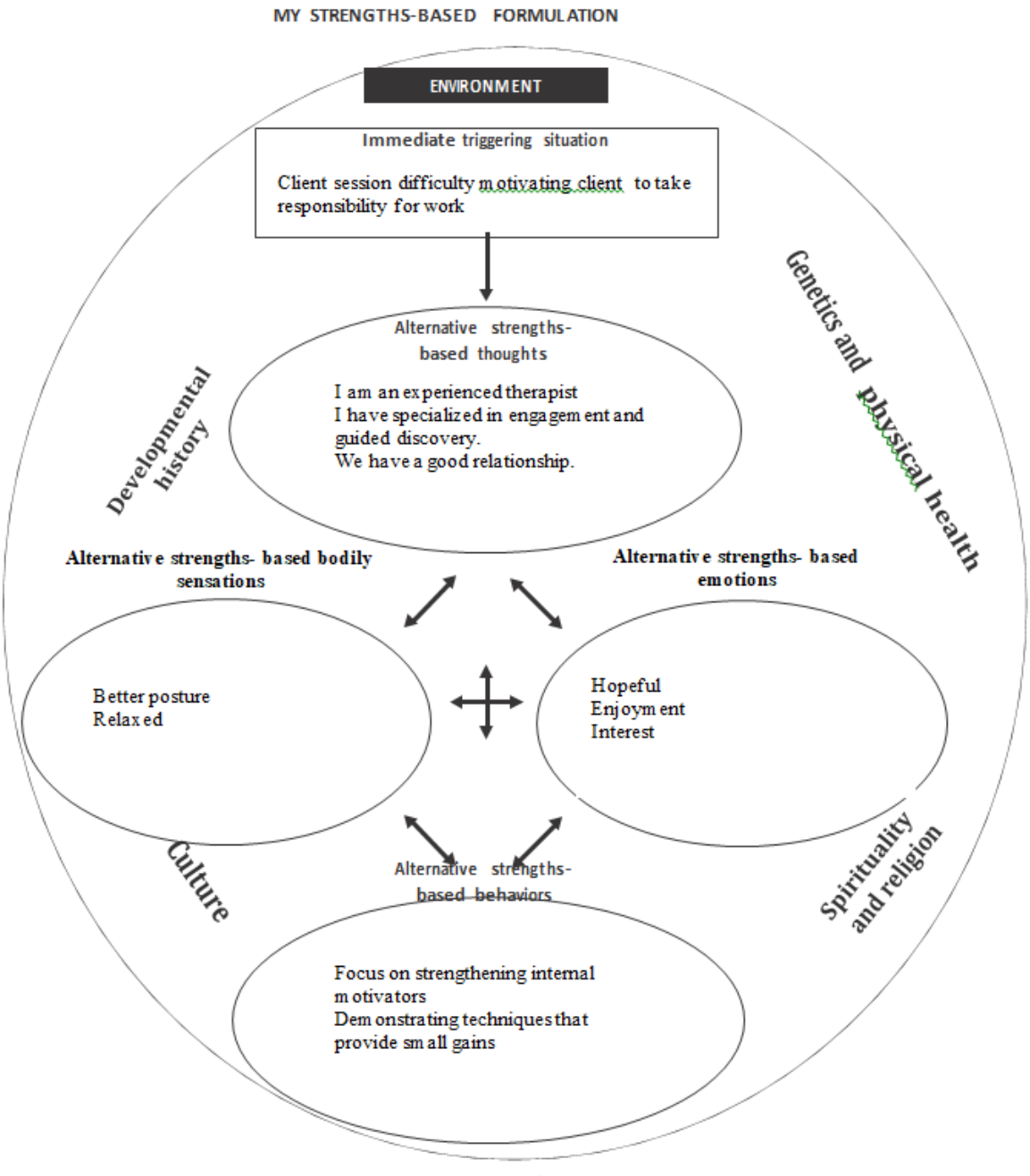
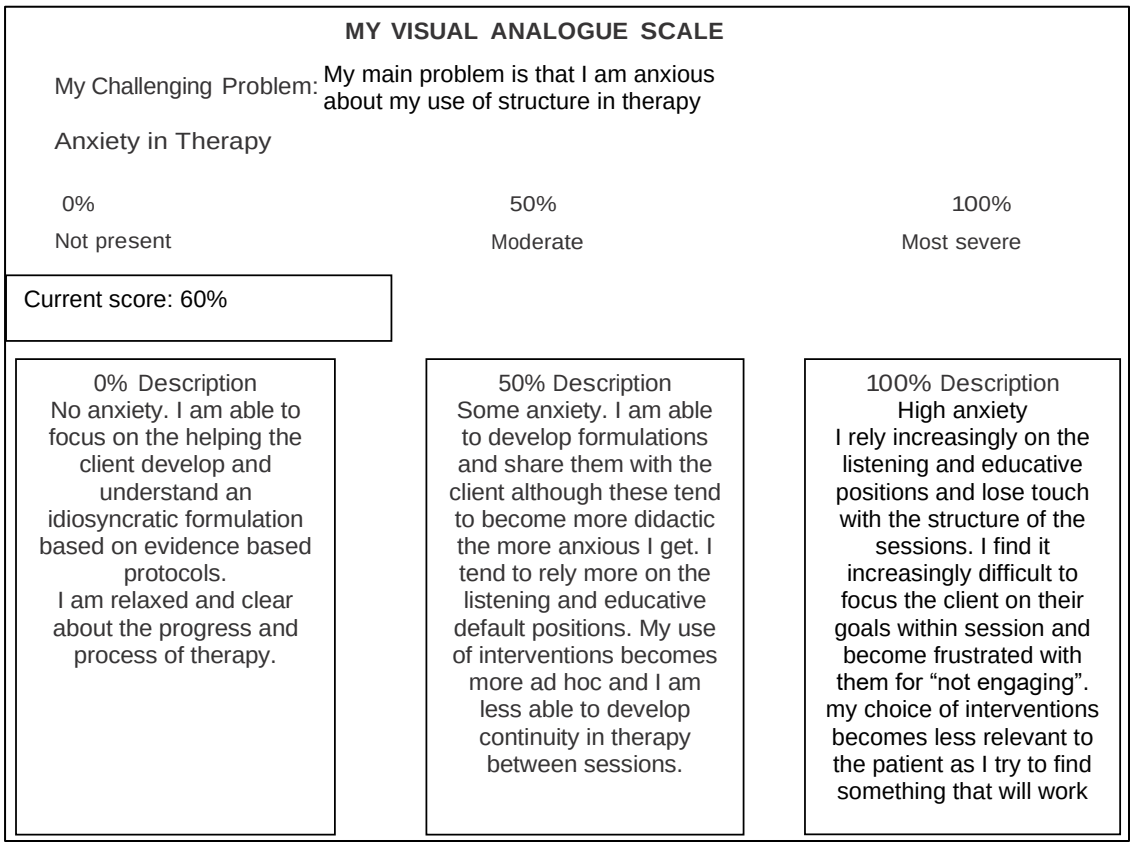


Figure 3

Visual Analogue Scale of Presenting Problem



These, most simple of formulation models, helped me to explore the cycles maintaining my challenging problems and to identify behaviours such as avoidance that might be impacting on my practice in the form of therapist drift (Waller, 2009).

Addressing Therapist Drift

"I struggled a lot more than I thought I would, I noticed how I avoided trying, to avoid failing" Reflective Logs, p.97

From an early stage in the reflective process, it became clear that many of my anxieties about my professional skills related to the phenomenon known as "therapist drift" (Waller, 2009), in part due to lack of current experience and practice. The term therapist drift refers to the process whereby a therapist fails to provide treatment in the most evidence-based manner. Reasons for this could be

external, i.e., the therapist not being adequately trained, or that the therapy is being conducted in an organisation that does not allow it to be carried out according to best practice; or due to internal factors such as personal decision making by therapists themselves. Waller and Turner's (2016) review of therapist drift suggests that these internal factors can be related to a number of issues, including the therapist's own beliefs about therapy, their emotional state, or their overconfidence in their ability to provide therapy in a more effective way than that determined by the evidence base. A core component of therapist drift is misuse of core therapeutic techniques (Waller, 2009; Waller & Turner, 2016). The SPSR programme addresses this by directing participants to use both cognitive and behavioural CBT change methods, which are core to CBT practice, to work towards their goals. This was perhaps the aspect of the programme that, I believe, had the greatest day to day impact on my therapy practice. It enabled me to gain both the benefit of using an evidence based method to address my challenging problems, and to gain direct experience and practice of using said method in practice, with myself as the client. These core components of CBT covered two main areas of practice, working with behaviours, and with cognitions

Working with Behaviours (modules 3-5). Behavioural techniques are some of the most effective in CBT and are often recommended as the first line of treatment in depression and anxiety (Dimidjian et al. 2014). There are a wide range of behavioural techniques and applications in CBT and the one proposed in the module was adapted from a form of Behavioural Activation (BA) developed by Richards and White (2011). This asks the participant to place necessary, routine, and pleasurable activities on a hierarchy and work through them over a period of time, starting with the easier items and building up to the more difficult ones.

This section was helpful in beginning the process of change, though it could be argued that it was a little too general in terms of activities, in that it did not focus specifically on goals. BA is a technique primarily used for depression (Dimidjian et al. 2014; Richards and Whyte, 2011) and, as such, is a broad reaching therapy that addresses the multi-faceted nature of that illness. When working towards specific activity targets, it may have been more effective to choose a more goal focused approach from the start, for example adapting a graded exposure model, looking at avoided or

difficult activities, to work towards one's goal. As such the BA component of the programme did not gel well with my own internal motivators, making it difficult to progress with. However, the process of planning and recording involved in these modules had a significant impact in helping me to address the structural changes that had been bothering me in therapy and as such, were highly effective in helping me to address therapist drift.

Working with Thoughts (Modules 4-5).

"I was surprised how easy it was to identify (critical cognitions) *and I was surprised how impactful the* (most salient) *thought was when identified"* (Reflective logs, p.116)

Identifying and challenging critical cognitions is a key part of CBT; however I went into the working with thoughts section with a degree of scepticism. Like many techniques in CBT, cognitive restructuring seems to be most helpful when there is an issue that the person doing them feels strongly about. This was not the case for me as I did not view my cognitive misinterpretations about my practice as being particularly strong. Contrary to expectations however, the process brought up a number of deeper level cognitions that had a profound impact on my development. In particular the downward arrow technique (Beck et al., 1979), which is designed to uncover deeply held cognitions, was very helpful, and I was aware of resistance through this process, that was both emotional and physical.

"it was helpful to recognise how easy it is to avoid looking at (cycles of negative thoughts and behaviour)*, despite how easy they are to see"* (Reflective Logs, p.117)

I was able to uncover the thought that I was not a good enough therapist to guide and supervise others and working through this using a thought record (a common technique used in cognitive restructuring (Beck et al., 1979)), was more helpful in balancing this cognition than I expected. This had a direct impact on my practice in that it *"reinforced my belief in the importance of really clarifying the (most salient) thought."* (Reflective logs, p. 116), as well as helping me to explore an issue that was bothering me. In this way the learning was helpful both in enabling me to identify my own cognitive misinterpretations and critical self-beliefs; and in gaining significant insight into the client experience.

Improved Client Understanding or Empathy.

"It is easy to avoid looking at troubling areas and it can induce a lot of resistance when you do" Reflective logs, p.119)

The third area of learning regarding my practice as a therapist came from a sense of increased empathy with clients, born from my own difficulties engaging in therapy and SPSR practices. These were amongst the most thought provoking aspects of the programme. I experienced both internal resistance to observing and reflecting on my own vulnerabilities; and a number of external obstacles to regular practice, such as other work or family priorities. I was particularly surprised by the degree to which my own resistances, or "security operations" (Leahy, 2012; Safran & Segal, 1990), were triggered by the change process. Resistance has many potential causes (Leahy, 2012) but can be seen as a process, enacted by the mind in response to perceived threat, and can lead people to go to lengths to avoid thinking about or addressing, aspects in therapy that can make them feel vulnerable (Safran & Segal, 1990). I encountered resistance throughout the programme, but it was initially evident when practical tasks, such as activity diaries were necessary. These practical tasks are akin to homework assignments, the completion of which have a significant impact on the effectiveness of a course of CBT (Kazantzis et al., 2016), and which are essential when completing the Inside Out programme. My difficulty engaging in the programme is demonstrated in fig. 4, which shows that the amount of time spent on SPSR in a given week fluctuated greatly in the early weeks.

These experiences of resistance and avoidance were useful in helping me to improve my understanding of the client experience. Whilst I have always been intellectually aware of the difficulties that clients may face engaging in the therapy process, experiencing them myself helped me to develop empathy with clients who may be struggling to engage on a more experiential and emotional level. It also prompted reflection on the need to prepare clients for the therapy process, and in particular "*to let people know about the possible emotional impact"* (Reflective logs, p.116) of engaging in certain therapeutic techniques.

These experiences were similar to those reported in other studies, as the development of therapeutic empathy is commonly reported by therapists undertaking SPSR (Bennett-Levy et al., 2003). It is also one of the factors cited in support of therapists experiencing their own therapy (Macran & Shapiro, 1998).

Self-report measures and perceived confidence in CBT skills.

"I think it will help me to focus on structure and change methods more. Also to plan my sessions in advanced and refer back to the agenda" (reflective logs, p.118)

Self-report scales that I completed before and after the programme concord to a degree with my reflective account that my confidence in my therapy increased over the course of the programme (see table 2). The CTS-SR psychometrics completed at the beginning and end of the study showed increases in confidence in eight of the fifteen areas covered by the questionnaire, including most of the areas associated with session structure (Agenda, Pacing, and professionalism), which were related to my first goal of "improving structure in therapy". However, the expected improvements in technique based fields, such as use of cognitive and behavioural techniques (associated with my second goal of improving use of "change methods") were not evident.

Table.2

CTS-SR ratings pre and post SPSR programme

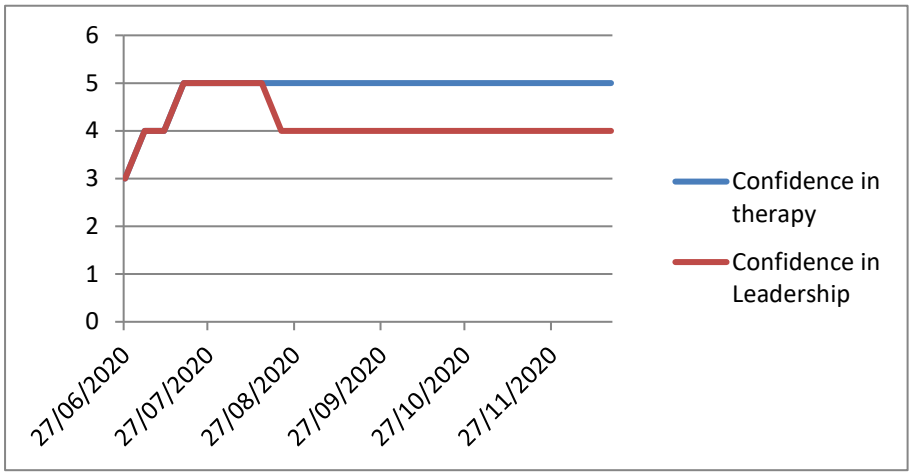
		Pre Programme	Post Programme
1	How much confidence do you have in yourself in your role as a cognitive therapist right now?	6	8
2	How much confidence do you predict you will have as a cognitive therapist in one year's time?	5	8
	Rate your current level of skill as a cognitive therapist		
i	General Interview Procedures		

3	Agenda setting	7	10
4	Eliciting client feedback	5	8
5	Collaboration	8	8
6	Pacing and Efficient Use of Time	5	6
ii	Interpersonal Effectiveness		
7	Empathic Skills	7	7
8	Interpersonal Effectiveness	8	8
9	Professionalism	8	10
iii	Specific Cognitive Behavioural Techniques		
10	Use of Guided Discovery	8	9
11	Case Conceptualisation	8	8
12	Focus on Key Cognitions	7	7
13	Application of Cognitive Techniques	7	7
14	Application of Behavioural Techniques	8	8
15	Use of Homework	6	8
	Total 3-15	92	104

This perceived improvement in structure was most noticeable during the early stages of the programme, when I was reflecting on initial resistance, consciously going over the core CBT skills in the programme and focusing on bringing them into my practice. When weekly self-report scales are viewed graphically an early increase in confidence in both therapy and leadership time was evident, concurring with my reflections.

Figure 4

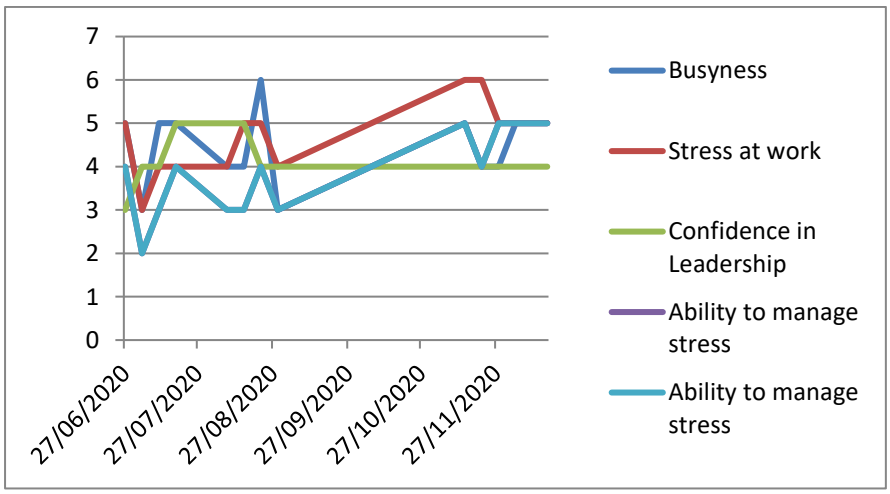
Changes in confidence over time



However, whilst confidence in therapy remained high, confidence in leadership reduced after the initial period. One possible explanation for this was the increased stress and busyness due to the pressures of leading my team through the Covid-19 pandemic. As can be seen in Figure 5 busyness, stress and ability to manage stress all increased concurrently over the mid to late period of the study, at around the same time that confidence in leadership reduced.

Figure 5

Confidence: leadership, stress at work, ability to manage stress and busyness over time



Helpful learning or insight about myself

"I think working towards my new ways of being has identified how entrenched my old ways are" (Reflective logs, p.249)

Self-learning, outside of that related to clinical practice, took two primary forms. Helpful practical learning related to self-management skills and techniques, such as using relaxation and breathing techniques, or daily planning techniques, were plentiful throughout the programme, and felt of real practical benefit. Reflections about myself, which were sometimes unpleasant, were also very useful in helping me to identify some of the areas that were holding me back. Notably the more self-criticising of these were made during the early parts of the programme, and tended to follow challenging parts of the programme that I thought would be easier to complete. The majority of the broader, and more insightful learning about myself, occurred towards the later chapters. These latter modules move away from more widely practiced CBT techniques, to focus on schema level work using the authors' "Ways of Being" model, which benefits from further explanation.

Traditional CBT draws on a multi-level cognitive processing theory, where surface thoughts, known as negative automatic thoughts (NATs) (Beck et al., 1979), which are most closely linked with specific situations and events, are seen through the lens of deeper processing. This, deeper processing is subsequently separated into two levels, those of Rules and Assumptions, about our lives, such as "if I don't try my hardest I will fail", and still deeper Core Beliefs, such as "I am worthless" or, "the future is bleak", or "other people will harm me". These deeper level cognitions tend to be more rigidly held, and also more multifaceted and generalised, influencing many areas of our lives (Beck et al., 1979). The "New Ways of Working" aspect of the Inside Out programme primarily addresses the rules and assumption level cognitions but also touches on core beliefs to a degree. In working through this part of the programme I became very aware of older, less helpful assumptions that I did not realise that I still held, such as "if I don't apply myself, I can't be found wanting"; and "if I try something I must succeed". Using the techniques provided however, I was able to challenge these, and develop a number of assumptions about new ways of being, such as, "not everything I do reflects

on me as a person" or "I don't have to do everything all at once". This insight fits with my greater knowledge of CBT therapy but I was surprised by how far from my original goals my exploration had come, as these realisations were indicative of a broader state of mind, that impacted on other areas of my life. In terms of personal development this was very helpful for me, and a worthwhile experience, but I was not convinced that it was either necessary or relevant to the SPSR skills development process (this issue is discussed in great detail in the "less helpful" section below). The programme then led me through a process of working through these rules and assumptions, using cognitive techniques such as behavioural experiments, an experimental change method in which cognitions are tested against real life experience (Bennett-Levy et al., 2004). Having worked therapeutically with people with very similar rules and assumptions for many years, it came as a surprise that I had been harbouring so many unhelpful beliefs, and this gave me more insight into the client experience. In particular I was very aware of not just the cognitive and emotional resistance to acknowledging these cognitions, but also the physical sensations of resistance that were triggered when I attempted to challenge old behaviours and develop new ways of being.

What was less helpful?

Despite my overall positive impression of the programme there were a number of areas that I found less helpful or distracting from the benefit of the whole. Whilst not wholly negative, these were highlighted in my general reflections on the programme and could best be described under the headings of "making things too simple"; "loss of goal focus" in the programme; "similarity to therapy"; and "resistance and avoidance". All of these factors contributed to my most overarching concern about the practicality of the programme, that of the "time and emotional commitment" required to undertake it.

Simplicity

"Focusing on (activity and emotions) *was not difficult…as expected by the model."*

(Reflective logs, p.93)

Whilst simplicity in learning is to be commended, the Inside Out programme is designed for qualified CBT therapists and PWPs, or at least those who have a good knowledge of CBT processes. As such I found some of the theoretical explanations and a few tasks to be over simplistic for the presumed level of understanding and experience of the reader. Whilst this was not especially counterproductive in the moment, I felt that this unnecessarily lengthened the programme, which could have been more concise and focused.

Loss of goal focus

"I think the Behavioural Experiments were tricky when applied to the underlying assumptions as the assumptions were not specific to work" (Reflective Logs, p.184)

As discussed in the previous section, I struggled at times to maintain my focus on the goals that I had set myself at the beginning of the SPSR process. This was particularly noticeable during the latter stages of the book, as the specific CBT practice, and goal focused learning of the early modules gave way to a more general self-improvement focus in the "New Ways of Being" chapters. Whilst these practices were helpful overall, they did not contribute towards my goals of improving structure in therapy and improving the use of change methods, in the same way that the earlier modules did. This shift from surface level NATs to deeper level processing, could be seen as a natural progression in terms of content, indeed a number of CBT tuition texts start at the NATs level before moving to schema level change (e.g. Greenberger and Padesky, 1995). However, in the context of a skills improvement programme such as Inside Out, the shift to more generalised thinking led to an exploration of the individual as a whole, which made focusing on overcoming specific goal related issues more difficult, as the exploration of the wider self-took precedence.

Similarity to therapy

"*It is getting more difficult to separate the process from therapy goals"* (Reflective logs, p.171)

Completing the inside out programme was both challenging and emotionally stimulating. Whilst this is necessary to a degree in any change process, I felt that the line between a professional

development programme and self-therapy became blurred for me in the later stages of the book. Developing insight into oneself is a core component of many psychological therapy training programmes and, from the perspective of advocates of the "therapy for therapists" approach this wider exploration of the self is beneficial (Macran & Shapiro, 1998). However, in the case of Inside Out, the authors are at pains to highlight that whilst the programme mirrors the therapy process, it is "not designed to be "self-therapy" (p.19) and as such I was not prepared for the degree of personal change that this would trigger, not the stress and vulnerability that this would induce in me. As such, I am not convinced that this degree of intensity is necessary for the programme to meet its goals.

Resistance and avoidance.

This experience triggered a high degree of internal resistance in me, with accompanying avoidance behaviours. With hindsight this was present throughout the programme; however, it was not until the latter stages, in which the line between professional development and self-therapy became more blurred that it really became evident. The decision to categorise "resistance and avoidance" as an unhelpful aspect of the programme was a complex one, and it could as easily have been explored in the previous section. In particular, it could be argued that the overcoming of these resistances is central to any progress made, and with this I would agree. However, the intensity of this resistance was surprising, and at times out of proportion to the benefit to my practice. On reflection, it might be beneficial to place more emphasis on this in the early stages of the programme, so as to prepare the user for the experience. Options for preparing participants for the expected resistance could include the use of motivational interviewing techniques (Rollnick & Miller, 1995) or a focus on recognising ones motivational position on the Cycle of Change (Prochaska & DiClemente, 1986). Using these techniques might help develop internal motivation and identify possible resistances at an early stage, easing progress through the programme.

Physical resistance. One component of the experience of resistance that was particularly interesting to me however, was the focus on physical experience. At times I experienced an almost physical reaction to pushing through the resistance when it came, which sometimes came in the form

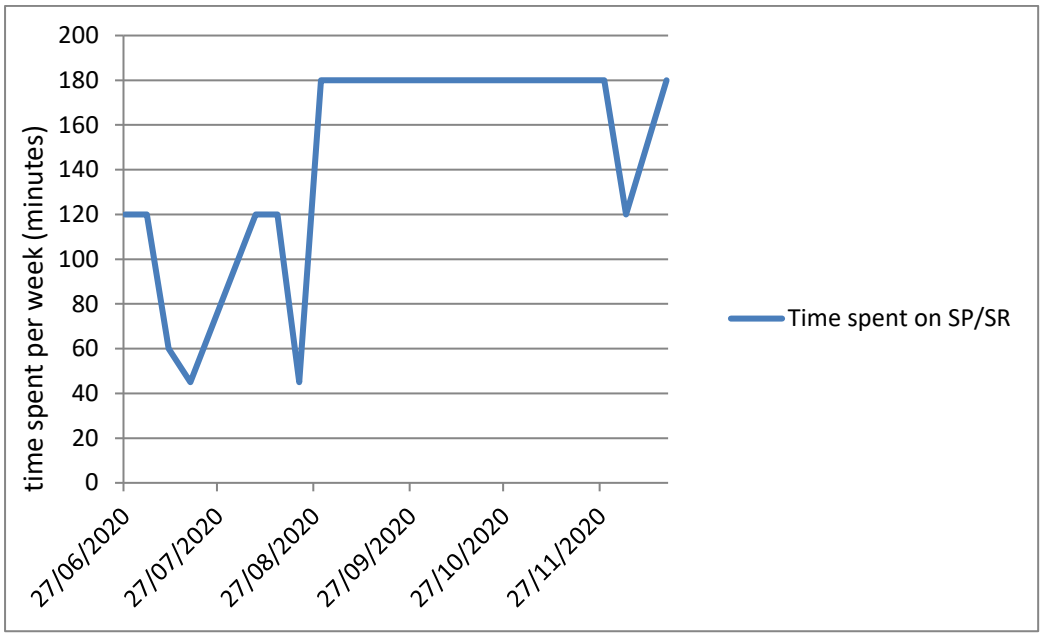
of a feeling of nausea, but more often as a freeze effect that made it very difficult to move forwards. Intrigued, and a little disturbed by this I widened my reading around the subject, drawing on works by Kahneman (2011) and McGonigal (2011). Through this I developed an understanding of willpower based decision making in the context of sympathetic nervous responses, in which the elevated stress associated with the resistance pushes one towards fight/flight/freeze behaviour related to the task at hand. This increased arousal, rather than motivating me led to what Kahneman describes as system one, or fast/reactive thinking which was reducing my ability to plan and think logically (system two thinking), decreasing my ability to move through the resistance. In contrast, by developing calming, parasympathetic responses to stress and resistance, through the use of short breathing exercises, I was able to reduce the resistance effect and make it easier to proceed. Of equal help were McGonigal's (2011) techniques designed to identify and locate the somatic aspects of resistance. Doing this enabled me to increase my self-awareness, helping me to take a step back and challenge automatic, habitual avoidance behaviours.

Time taken and difficulties prioritising the programme

This last area of concern about the programme is perhaps both the most important, and an unfair one to place at the door of the manual itself, as the authors were clear from an early stage how long the expected time commitment would be. The programme recommends a commitment of one to two hours per week for the first six modules followed by two to three hours per week for the second six, giving an overall time commitment of 18 – 30 hours over twelve weeks, which I found to be accurate (see fig. 6).

Figure 6

Time spent on SPSR



However, the significant commitment of time required could be a barrier to its routine implementation in a busy clinical setting. Over the course of the programme I found prioritising time for SPSR extremely difficult, especially in the early stages, where the time spent varied greatly from week to week. Reasons for this are numerous. As already noted, one of the learning points of the programme for me was recognition of just how much my internal resistance was holding me back, pushing me to prioritise other things as a form of avoidance. However, it was also very difficult to find the time either in or outside of work hours to complete the programme, given other work and home life priorities. With this in mind, the timing of the programme completion cannot be overlooked. In 2020 the NHS and health services around the world were under unprecedented strain due to the Covid-19 pandemic. Whilst our service was not directly involved in treating the physical symptoms of the illness, we were acutely aware of the impact that it, and the associated lockdowns, were having on the mental health of the nation. As a primary care mental health service our team had a key role in supporting both the general public and keyworkers over this period. Being in a leadership position and responsible for adapting the service to the changing need, I found the pressures on my time, as well as my mental and physical wellbeing, to be intense. As a consequence

there was a period of time when it was not possible to commit to the programme, and data were not collected from 29/8/20 to 14/11/20.

It was following this period however, that I returned to the programme with renewed vigour. As will be noted in figure 6, the time spent on SPSR went from being highly variable to quite stable mid-way through the programme. This is due to the fact that on my return to the programme, I realised that I would need to be a lot more disciplined with my time if I was to complete the programme and I was able to utilise the skills that I had learned throughout the process to help me do this.

Review of the Study Questions

The aim of undertaking the programme was explore its potential utility as a tool for developing therapist skills in the workplace. As such I sought to investigate the following questions;

i. Does undertaking the programme of SPSR have a noticeable impact on the wellbeing of the CBT therapist in an NHS IAPT service?

ii. What are the key learning experiences of the therapist undertaking the study and how do these affect my opinions and beliefs about CBT as a Therapy.

iii. What are the time and effort commitments of undertaking such a programme and is it feasible for CBT Therapists to undertake it in a busy "payment by results" service?

Does undertaking the programme of SPSR have a noticeable impact on the wellbeing of the CBT therapist in an NHS IAPT service?

I found the period of time that I undertook the programme to be acutely stressful, but this must be taken in the context of the Covid-19 crisis that coincided with the study. To their credit the authors do highlight that undertaking SPSR during times of acute stress is not always advisable, and they reinforce the need for self-care throughout. However, had this not been part of my PhD research it is unlikely I would have completed the programme in isolation. My experience of the programme was far more challenging than anticipated, and whilst I value the experience, the resistance that I felt to engaging in parts also had a negative impact on my stress levels. As such I would not use the course as part of a staff wellbeing programme in the way that therapy for therapists might be used,

without considerable thought; and rather would echo the authors, in counselling participants to think carefully about undertaking it if they are at a particularly stressful time. However, the overall learning has been very helpful, and having completed the programme I would reflect that both my confidence at work and ability to undertake new challenges have improved, indicating a lasting positive effect on my wellbeing.

What are the key learning experiences of the therapist undertaking the study and how do these affect his opinions and beliefs about CBT as a Therapy.

The Inside Out programme offered opportunities for learning in a number of areas, and my experiences of learning echoed many of those recounted by participants in previous studies (Bennett-Levy et al., 2001; Bennett-Levy et al., 2003; Davies et al., 2014; Thwaites et al., 2017). At its most simple it offered opportunities to challenge therapist drift, through practicing techniques on myself. This had the dual effect of refocusing my mind on the core elements of CBT, making it more likely that I would draw on them in therapy; and providing experience of the challenges of completing tasks. Specific areas, such as downward arrowing and thought challenging, were also a lot more impactful than I had expected, and experiencing how difficult it can be to prioritize, engage in and plan for homework tasks has led me to a greater empathy for clients who struggle with this. I have also developed an increased recognition of the need to explore internal motivators with clients, and to help them to work through blocks to therapy. There was however another level of learning taking place during the programme. In particular, the New Ways of Being, stages of the programme helped me to understand my own learning process and behaviours in "new ways". Whilst I do not feel that this learning was as necessary, in terms of improving my therapy as that gained through the earlier modules, it is my opinion that the changes provoked by the later stages of the book will have a wider impact on my life.

What are the time and effort commitments of undertaking such a programme and is it feasible for CBT Therapists to undertake it in a busy "payment by results" service.

Whilst it is important be very cautious about generalising from a self-reflective piece of research such as this, the insight I gained from my own experience has been useful in reflecting on the Inside Out programme's possible uses. One of the key reasons for undertaking the programme was to explore its utility as a CPD tool, either universally, or as a support programme for therapists who were struggling with their work. Records of time spent on SPSR over the course of the programme indicate that it took at least as long as the time suggested by the authors. This also did not take into account time reflecting outside of SPSR sessions and struggling to motivate myself. Reflective logs indicate that it also required a high degree of effort at times. As such I would recommend that the programme be accompanied by structured workload reduction in order to accommodate it. This has potential implications when considering rolling out the programme on a service wide basis, particularly in a payment by activity service. Reflection on the time taken, and stresses involved in the programme do not lead me to think that it would be appropriate as a universal, compulsory CPD tool, however it may have utility for therapists who are motivated to engage in it, or as a tool for helping therapists who are struggling with therapist drift.

Conclusion

The purpose of this thesis is to explore practical applications of research, with the aim of improving CBT provision. This chapter aims to explore both the practicality and use of SPSR from a very personal perspective. Whilst I had originally planned to explore the topic from the perspective of a manager, questioning its use for other, less experienced therapists, it quickly became clear that the Inside Out programme pushed me to explore my own strengths and limitations both as a therapist and human being. Both personal reflection and self-report data suggest that the Inside Out programme has helped me to improve my therapy. In particular the earlier modules, focusing on skill use and therapist drift had a significant impact on refocusing my attention towards evidence based approaches. It also helped me to develop empathy for clients, especially when they are struggling with aspects of the therapy process. However, I do not believe the latter stages of the programme, whilst enlightening and very helpful in a general sense, had the same direct impact on my therapy provision. As such, and as discussed above, I do not feel, given the time commitments and potential stresses involved in

undertaking the programme, that the model in its entirety, is a practical method for improving therapist competence on a team wide basis, especially in a payment by activity service. However, as an optional provision, or used alongside increased supervision as part of a package to support therapists who are struggling, I believe that Inside Out can be a valuable resource in helping therapists improve the quality of their CBT.

Limitations of the study

One potential limitation of this paper was that it was conducted in isolation. First person research suffers in that our reflections are biased by our perspective, making it difficult to uncover some of our more deeply held frames (Taylor, 2004). Because of this, first person research can be best supported by being conducted in the context of a larger second person inquiry (Marshall and Mead, 2005). My own biases were also highlighted as I became aware of my desire to want to do well in this piece of work, potentially biasing my interpretation. The act of conducting the study alone also gave rise to more practical challenges and I am aware that I struggled to keep momentum up on the project. This is reflected in my difficulty keeping weekly reflective diary entries, partly due to a lack of time and partly due to other priorities consuming my energies and attention.

Both the issues of reflection and structure would have been aided had I been working alongside or supporting a second person through the project. For the brief period that I was able to meet with a colleague for regular supervision, it gave rise to a more collaborative reflective space, which motivated me to schedule my own reflective accounts. Much of the research into SPSR follows this collaborative approach and had it been possible to undertake the programme with another person, this might have both given rise to improved reflection, and allowed for peer support.

Addition to the knowledge base and implications for future research.

This paper has added to the existing research by providing an in depth exploration of the SPSR process that has not been undertaken at this level before. Its autobiographical nature has enabled me to fully explore and reflect on my experience in a way that is, I hope, of use to other practitioners and leaders considering using the model for personal and/or team development. There

are a range of opportunities for further research stemming from this study. Of these, a broader study exploring the mediators and moderators of any relationship between aspects of the SPSR process and therapy outcomes in a clinical setting might be helpful in fine tuning the current programme, or the development of new, more parsimonious ones. It would also be useful to see an evaluation of the Inside Out programme when adapted for a non CBT specialist audience, perhaps in a group format as a more general self-development programme. Finally, this paper has demonstrated that Reflective Topical Autobiography is an appropriate methodology for the exploration of therapy related learning, and it would be of benefit to develop similar studies relating to other areas of therapy training and CPD, such as exploring experiences of psychotherapy or psychology training programmes.

Chapter 6 General Discussion

Summary and synthesis

Overview

This thesis was motivated by the desired to use psychological and research methods to explore options for improving CBT service provision in the NHS. It has explored this proposition, following the model prescribed for the PhD in Professional Practice: Psychological Perspectives at Canterbury Christ Church University (Canterbury Christ Church University, 2014). Recall that the PhD in Professional Practice follows a slightly different structure to that of a more traditional PhD. Rather than following a single strand of research to its conclusion, the PhD in Professional Practice requires that the author builds a portfolio thesis that approaches a field of study that is relevant to their professional practice, from a variety of directions. This involves the undertaking of four core projects; a review of the literature, an investigative research project that adds to the existing knowledge in the field of study, a service related research project or evaluation, and a more personal report, enabling reflection on the participants' field of professional practice (Canterbury Christ Church University, 2014).

This thesis explored its central theme from two main perspectives. Section 1 (consisting of a critical review of the literature and an investigative research project) explored the possible nonclinical predictors of therapy outcomes related to clients' personalities and attitudes towards individual CBT for common anxiety and depressive disorders. It then investigated a tool (the CBT-Suits (McLellan et al., 2016)) designed to make use of some of these factors in predicting outcomes in a clinical service, in the hope of integrating it into the assessment and therapy processes. Section 2 (comprising of the service related project and report of professional practice) approached the subject of improving the quality of CBT provision from another perspective, that of the therapist. Chapter 4 explored the experiences and practicalities of providing training to CBT novices as part of the RCPsych core psychiatry training programme, and Chapter 5 the personal experiences of the author undertaking an intensive CPD programme (SPSR) in a busy clinical service. The aim of both these chapters was to

investigate the support and training needs of individuals undertaking training and development in CBT, as well as the pressure placed on providers, in order to explore ways of maximising the potential learning and improvement to services.

Section1

Section 1 began with a review of the literature (Chapter 2) surrounding pre-treatment psychological predictors of outcomes in CBT. The literature review analysed 26 primary studies and 8 pre-existing reviews, in which face to face CBT for anxiety and depressive disorders was an active treatment, and predictors of outcome were investigated. Eight categories were identified as being potentially predictive of outcome. Of these, client motivation (Miller & Rollnick, 2003; Ryan & Deci, 2008) and dysfunctional attitude (Beck, 1964; Weissman & Beck, 1978) were identified in previous reviews as correlating significantly with treatment outcomes (Hamilton & Dobson, 2002; Keijsers et al., 2000). A further six categories of predictors were identified; these were Expectancy/Credibility, Treatment preference, Beliefs about illness, Interpersonal styles/problems, Personality and Multi-factor tools (consisting of the Suitability for Short Term Cognitive Therapy Scale (SSCT) (Safran et al., 1993)). There was good evidence that both client personality and scores on the therapist rated SSCT correlated significantly with therapy outcomes, but less clarity over which components of the SSCT offered the most predictive validity (Mhyr et al., 2007, Renaud et al., 2014). There was mixed evidence for relationships between Expectancy/Credibility, Beliefs about illness and Interpersonal styles, and therapy outcomes. No evidence was found of a relationship between treatment preference and therapy outcomes.

Chapter 3 (the investigative research project) investigated the predictive validity and factor structure of the CBT-Suits (McLellan et al., 2016; McLellan eta l., 2019), a promising tool for the prediction of outcomes in CBT, in a clinical IAPT setting. As published, the CBT-Suits is a 13 question self-report scale that draws on both CBT theory and research to attempt to predict therapy outcomes in CBT. It has a two level, four factor structure, consisting of Overall Score, CBT Rationale, Insight and Behaviour. The chapter also made use of a recent (as yet unpublished) study of

the CBT-Suits (McLellan et al., 2021), provided by the lead author of that study (L. McLellan, personal communication, October 20, 2021). McLellan et al.'s (2021) study suggested a significant alteration to the CBT-Suits, that of its conversion from a 13 question scale to an 11 question one, whilst maintaining the core four factors. As a result, the factor structure of both the 13 question and 11 question scales were investigated. Whilst both scales had a reasonably good factor structure, the data from this study concurred with that of McLellan et al. (2021), indicating that the 11 question variant was both more parsimonious and more robust. Consequently, the 11 question CBT-Suits was used as the primary measure in an investigation of the predictive validity of the CBT-Suits in the IAPT sample. The CBT-Suits did not demonstrate and predictive validity for outcome severity, over and above that provided by initial symptom severity, however.

Section 2

Section 2 of this thesis focused on the subject of therapist competence as a means of improving therapy provision, in particular, the area that is arguably most under the control of service providers, therapist training and development. Chapter 4 (the service related project) investigated a CBT training and supervision programme, that was developed to meet the needs of core psychiatry trainees undertaking Royal College of Psychiatry (RCPsych) training towards accreditation as a consultant psychiatrist (Royal College of Psychiatrists, 2015). Eleven current and former core psychiatry trainees completed the Experiences of CBT Training and Supervision Questionnaire designed for the study. This questionnaire investigated trainee evaluations of their competency development, the quality and importance of different aspects of the programme, and their qualitative experiences of the course. Nine participants also gave permission for the use of their post case competency assessments. The programme was universally well received, and all participants' self-ratings of CBT competency, skills and knowledge increased significantly after completing the course. Content analysis identified 32 categories and subcategories for analysis. All participants passed the programme with an average of 31% satisfactory and 69% good grades.

Chapter 5 (the report of professional practice) utilised primarily qualitative methods to explore the experiences and practicalities of a single skilled CBT therapist, undertaking an intensive CPD programme, in a busy clinical setting. The author was a researcher/participant in a reflective topical autobiographical study (Johnstone, 1999) that looked in depth at both the learning experiences and struggles of undertaking an intensive programme of self-directed study known as Self Practice and Self Reflection (Bennett-Levy et al., 2001; Bennett-Levy et al., 2015), whilst also holding a clinical caseload and leading a busy service. Content analysis of reflective logs indicated that the programme was helpful in terms of enabling the participant to address worries that they had about their therapy delivery, which had arisen due to a reduced clinical caseload. Later stages of the programme also enabled reflection on a deeper level through the programme's "New Ways of Being" (Bennett-Levy et al., 2015, pp.155-253) modules. However, whilst this reflection was helpful in terms of wider personal growth, it was experienced as less helpful in terms of improving clinical competence. The programme also brought with it a number of personal and professional challenges, not least in terms of prioritising the programme whilst leading a clinical health service through the Covid-19 pandemic (discussed in the Limitations section below). As such, whilst the programme must be taken in the context of when it was completed, the author was not convinced that the SPSR programme, in its entirety, would necessarily be the best use of resources if rolled out to the wider team, unless the therapists undertaking it had a specific motivation for doing so. The author reflected however that, were his experiences to be shared, the programme could be beneficial for use alongside increased supervision, as a means of supporting therapists who were struggling with their therapy delivery.

Synthesis

This thesis draws together two important areas research, that potentially relate to the quality of CBT clinical services. The identification of personal predictors and consequently potential barriers to therapy outcomes can be of benefit to clients, therapists, and supervisors alike, particularly when therapy is not proceeding as hoped for, offering participants' insights into both the nature of clients'

strengths and the analysis of resistance (Leahy, 2012; Safran & Segal, 1990). However, this information is only useful if therapists are competent in their provision of CBT.

In exploring what both the therapist and clients bring to therapy the thesis highlights that therapy is a joint process, and its success depends on a number of complex factors brought by both parties. A good example of this is seen in the therapeutic relationship or alliance, the strength of which has shown correlations with clinical outcomes in CBT and wider psychotherapies (Cameron et al., 2018; Horvath & Symonds, 1991; Martin, et al., 2000). The relationship between therapist and client has been acknowledged as an important component of psychotherapy process since the days of Sigmund Freud (2014), although how it is defined in modern psychotherapy is the subject of conjecture (Noyce & Simpson, 2018). One commonly used description of the relationship across broader psychotherapy is "the feelings and attitudes that counselling participants have towards one another and how they are expressed" (Gelso & Carter, 1985 (p.159); Norcross & Lambert, 2001), but in Cognitive and Behavioural therapies the alliance is explored in a more structured way, and is seen as, as much the product of skill and technique of the therapist as their feelings towards the client (Leahy, 2008; Rachman, 1963). Leahy (2008) for example, identifies a number of factors that he believes contribute to the working alliance between therapist and client, some of which are truly shared, such as the compatibility between the therapist and the client's emotional philosophies and rational schema, but many that could be affected by what the therapist or client individually bring to therapy. However, the therapist does not only bring their personality to the relationship, rather how they present to the client can be seen as an amalgam of their personality and skill or competence as a therapist (Safran & Segal, 1990). There are a number of interpersonal factors such as therapist warmth, empathy, supportiveness, confidence, and perceived expertise that have all been shown to relate to both the therapeutic alliance and therapy outcomes (Feller & Cottone, 2003; Keijsers et al., 2000), and that can be taught to therapists, at least to some degree (Blackburn et al.,2001). There is also some evidence that therapeutic relationship is stronger when therapy is carried out by experienced professionals rather than trainees (Hadjistavropoulos et al., 2017). As such, whilst it is difficult to predict the particular relationship that will evolve between two human beings, and how

that interaction might relate to outcomes, it is possible to improve the likelihood of a strong working alliance through both effective training and supervision of therapists, and the identification of what the client may bring. Further investigation of the therapist alliance in the context of both client predictors of outcome and therapist competence is highly recommended.

Limitations of the thesis

Covid-19

The limitations of each individual study are addressed in the relevant chapters. However, there are some overarching limitations that affected more than one aspect of the thesis. One of the most obvious limiting factors has been the impact of the Covid-19 pandemic and accompanying lockdowns. This affected the thesis in multiple ways, particularly in Chapters 3 and 5, which were undertaken and written during this period. In Chapter 3 (the validation of the CBT-Suits) this significantly affected data collection due to a move from face to face, to videoconferencing as the main modality of therapy, making it much more difficult to complete questionnaires in session with patients. It also potentially affected the nature of the data received, as public mental health was significantly affected during the pandemic, at times as a result of practical life issues such as job security and illness (Panchal et al., 2020), which may have affected their response to CBT. Additionally, participants were not able to complete the full range of therapy related behaviours due to lockdown. However, it is not known whether either of these factors significantly affected outcomes in either therapy or the study.

The effect of the Covid-19 on Chapter 5 (the report of Professional Practice) was perhaps more profound, as the project bore a direct relation to the author's professional role as a service lead. As such, and given the additional workload placed upon the author, it was particularly difficult to prioritise time for the both the SPSR and written components of the project, over and above the demands of increased service load (around 30% higher than the previous year), staff welfare, development of specialist services for key workers and Long Covid sufferers, and engagement with the wider Primary Care Network to develop a unified health response to the pandemic. This was also

in the context of the author being diagnosed with Attention Deficit Hyperactivity Disorder (American Psychiatric Association, 2013) during this time period, the symptoms of which added to difficulties maintaining focus.

Cultural factors relating to CBT outcomes.

Another area that is not addressed as explicitly as it could have been in the thesis is that of cultural factors. Cognitive Behaviour Therapy and its precursors Cognitive Therapy and the Behaviour Therapies were predominantly developed in North America and Northern European cultures, drawing on research predominantly conducted with individuals from the dominant cultures in these regions (Beck, 1963; Beck 1969; Rachman, 1963). However, since that time CBT has spread to be used effectively across the world (Bennett-Levy et al., 2014; Kameoka et al., 2020; Kaysen et al., 2013). As such there is increasing interest in its applicability to the needs of individuals from cultures that may not have been considered during its development (Hays, 2014). Whilst it is clear that CBT can be an effective and evidence based therapy for people from a range of cultures, evidence is mounting that a culture first approach, listening to recipients and making culturally sensitive adaptations to both treatment and the training of therapists, is advantageous in maximising engagement and efficacy of therapy (Hays, 2014; Murray et al., 2014). Given this, there is scope to for increased studies investigating the cultural sensitivity of CBT amongst the diversity of cultures in the UK. However, it was not possible to include these factors in the predictive validity tests in Chapter 3, due to the moderate sample size, and the relatively small proportion of participants from non-white British ethnicities and backgrounds. However, with the benefit of hindsight, cultural factors could have been investigated in Chapter 4, the review of medical training in CBT. The participants in this study were from a variety of ethnic and national backgrounds, and were the study to be conducted again it would be appropriate to amend the Experiences of CBT Training and Supervision Questionnaire to enquire about whether the cultural and ethnic backgrounds of participants related to their experiences of the training programme. As a result of this, adjustments could be made as necessary to meet the needs of future trainees equally.

Implications for future research

This thesis raises a number of implications for further research. The most notable of these would be the continuing development of an easy to use tool to aid in the prediction of who CBT is most effective for, and from there a tool to differentiate between which therapies are most suitable for whom. The clinical implications of such a tool would be potentially groundbreaking, with potential uses across the therapy process, in screening, assessment, supervision, and of course therapy itself. In addition to this however, Chapters 4 and 5 raise interesting research questions about therapist training and development. Drawing on the information gathered in the review of novice CBT training it would be interesting to conduct a follow up study to ascertain the ongoing usage of the skills learned. Perhaps more interesting and clinically useful however, would be the development of the SPSR therapist development programme undertaken in Chapter 5. Whilst this programme was both time and labour intensive, it was also perceived by the author as very useful in terms of addressing therapist drift, particularly in its early stages. The development and implementation of this programme, alongside supervision and support, as a tool specifically for clinicians struggling to maintain their clinical skills and outcomes would be of potentially great benefit to clinical services, therapists and their clients alike. As a consequence the author plans to integrate this into the service that he leads, and to evaluate it in terms of clinical outcomes, staff wellbeing and cost/benefit to service. Should it prove effective, it will be offered to other services for their use.

Reflections on methodology and learning from the thesis.

This section contains personal reflections and learning from the PhD in Professional Practice programme. As such, and in line with its more personal tone, the narrative will be described in the first person. In this section the methodologies and learning from each of the main chapters will be addressed with the benefit of hindsight, having completed the programme.

Chapter 2: The literature review

In order to gain the most learning experience from the PhD programme I approached the design of each study using a different methodology. Chapter 2 stood out easily in this regard owing to its literature review design. With the benefit of hindsight however, there were a number of choices that could have been made differently. Chief amongst these was the decision about inclusion and exclusion criteria. The main purpose of the literature review was to explore the evidence base for the development of a pre-treatment predictive questionnaire in Chapter 3 (this was altered after the publication of McLellan et al.'s (2016) publication of the CBT-Suits). As such, given that the aim was to test this with an IAPT sample, the decision to focus on common depression and anxiety disorders was an easy one. However, after preliminary investigation of the literature it became clear that the breadth of the field was such that it could not be encompassed in a single literature review of this type. Additionally, given that there is some evidence that pre-treatment predictors may relate to outcomes differently depending on the modality of treatment offered (Speck et al., 2008), it was appropriate to focus the review on the primary modality in which the pre-treatment questionnaire was planned to be tested, that of individual face to face CBT. However, following the emergence of the Covid-19 pandemic and subsequent transfer from face to face to videoconferencing as the primary mode of engagement in the participating service, there is an argument for the inclusion of internet based CBT into the review. However, the review of pre-treatment predictors in online CBT brings with it a unique complication. The majority of what is often regarded as Step 2 or Low Intensity (in the IAPT context) intervention is provided online or via telephone, and there are a number of truly digital treatments that are provided exclusively online under the auspices of CBT (such as, MoodGym (Twomey & O'Reilly, 2017) and Silvercloud (Doherty et al. 2012)). However, these interventions are not CBT in its fullest sense and many of the studies described as internet focused CBT or iCBT (Hadjistavropoulos et al., 2017; Lewis et al., 2019) are in fact studies of internet based manualised CBT interventions that are very different in delivery to CBT as delivered by a psychotherapist. Whilst there is nothing intrinsically problematic about this it does complicate the review process, as the reviewer is required to distinguish between these different interventions in studies where this is not always explicitly stated. As such the predictors of outcome in internet focused CBT would have been

difficult to encompass within the scope of this thesis and would benefit from their own systematic review.

Chapter 3: Validation of the CBT-Suits

The ethics of pre-treatment outcome prediction scales

One area that was considered extensively before the commencement of the thesis was the ethics of pre-treatment outcome prediction scales as a whole, and the risk of medical gatekeeping (Pellegrino, 1986). As discussed previously, modern health services, including IAPT services are subject to the NHS constitution's sixth principle, the commitment "to providing best value for taxpayers' money" (National Health Service, 2015). As such, services are required to meet extensive targets in terms of the cost and effectiveness of services (National Collaborating Centre for Mental Health, 2021; National Health Service for England, 2021). The knowledge of who may or may not achieve better outcomes, on measures that a service is judged upon, could be quite powerful in this context, for good or ill. Such information could provide extensive benefit for the tailoring of services to meet individual need, adding value to both the quality of therapy and the cost effectiveness of services. Examples of this might include allocation to a more experienced therapist (or higher intensity of treatment), routinely offering additional treatment sessions to those who are most likely to find recovery the most difficult, or referral to a therapy preparation group or pre-treatment motivational interviewing sessions, which have shown promise for the long term reduction of symptoms (Westra et al., 2016). However, the temptation to screen out patients who may have the highest need, in favour of the those who are quicker and easier to treat, and therefore more likely to provide positive reporting outcomes, is one that cannot be ignored. This de facto conflict of interest risks placing service providers in the role of a negative gatekeeper (Pellegrino, 1986), running the risk of limiting the availability of treatment to those in the greatest need because they are least likely to recover (D. Veale, personal communication, March 3, 2018). As such, the dissemination of such a tool would have to be accompanied by training in its ethical use and, if incorporated into a national service such as IAPT, would need to be accounted for in that service's standards.

Use of the CBT-Suits

The original plan for this thesis was to develop a questionnaire based on the results of the literature review in Chapter 2. However, in 2016, as the review was completed, McLellan et al. (2016) published their first paper outlining the development and factor structure of the CBT-Suits. This led to the need for a decision, regarding whether it would be appropriate to continue with the development of an original questionnaire, or to contact Dr McLellan to discuss the possibility of evaluating the CBT-Suits in an IAPT setting. The decision to contact Dr McLellan was primarily based on four factors. First the CBT-Suits utilised a similar theoretical and evidence base to that covered in the literature review that had been completed for this thesis. Secondly, the CBT-Suits was very promising in early research, having been through a thorough development process, with good factor structure and showing early signs of predictive validity (McLellan et al., 2016). Third the publication of the CBT-Suits led to the risk that, if it was validated for a clinical population before the submission of this thesis, it could jeopardise the original contribution to the field that the thesis was designed to make. Finally, given the practice focus of this thesis and the motivation to use research methods to improve clinical services, it was more appropriate to make use of an existing tool that already showed promise as a predictor of outcomes than to take the additional time to design something else from scratch, potentially delaying its implementation into service. However, the CBT suits did differ in some regards to the planned structure of, what would have been an original questionnaire. Had the questionnaire been designed from scratch it would still have drawn strongly from the theoretical evidence base that McLellan et al. (2016) did. However, it would have relied more on the results of the literature review, asking more questions focused on the participants' expectations for therapy and , where possible aspects of their personality and interpersonal styles. It would also have drawn more strongly from the structure of the Suitability for Short Term Cognitive Therapy Scale (SSCT) (Safran et al., 1993). You will recall that the SSCT was well evidenced for the prediction of outcomes in CBT (Mhyr et al., 2007; Renault et, al., 2014; Safran et, al., 1993), but lacked practical application due to its therapist evaluated semi structured interview format, limiting its utility in time pressured clinical settings. McLellan et al. (2016) do address many of the same areas as covered in the SSCT, such as

those covering the ability to differentiate between emotions or belief in the cognitive rationale, but not others. The development of questions addressing other areas addressed by the SSCT, such as acceptance of responsibility for change, or the ability to form therapeutic alliances, whilst difficult to frame, might have added predictive capability to the factors addressed by the CBT-Suits.

Chapter 4: Evaluation of Core Psychiatry Trainee Short Case Training in Cognitive Behavioural Therapy

The first and perhaps most important methodological issue in Chapter 4 was an ethical one. You will recall that the RCPsych require all psychiatry trainees to undertake one short and one long psychotherapy case, and that in the participating Trust the short case utilised CBT as the chosen therapy. At first sight this is a highly beneficial process, giving trainees an opportunity to experience CBT first hand, gaining knowledge of basic methods that they can use to enhance their core psychiatric practice, such as Socratic dialogue and case conceptualisation, and also helping them to better understand who might benefit from a CBT approach, potentially improving their referral accuracy. However, a core question was in my mind throughout the process; whether it is ethical to enable practitioners, with very little CBT training, to undertake therapy with a client for whom they and the service you have a duty of care? The answer to this question was to a degree, a hypothetical one, given that the programme was nationally sanctioned by the RCPsych, and would occur regardless of whether the study was conducted, however the decision to participate in this process was still one that bore reflection. As discussed in Chapter 4, Jagsi, and Lehmann (2004) suggest that any practitioner training must meet the core principles of Respect for Individuals, Beneficence and Distributive Justice, and it is the assertion of this thesis that these principles were met. That said, it is important for the training to be as robust as possible, and as such the evaluation was of import in order to meet this need. This is evidenced in the evaluation feedback, which indicated that in the opinion of at least one respondent the training and supervision received was better organised and of a higher standard than that received in other Trusts within the Deanery. But is was also important to act upon the results, and a number of improvements were made to the programme as a result of the evaluation that served to further safeguard patients. Chief amongst these was the decision to site core trainee

short case work within the primary care IAPT service, hosted by the Trust. This allowed for more suitable primary care patients to be allocated to the trainees, and also allowed for more robust patient feedback, recording and psychometric monitoring of case work.

Given that the purpose of the study was to "enhance professional practice associated with the organisation or delivery of services" (Canterbury Christ Church University, 2014, p.9), my motivation in undertaking an evaluation of this training was not just academic but stimulated by a desire to provide the best possible training and supervision to the trainees, not just for their benefit but for the benefit of the clients that they saw. In effect, my thinking was, if they are going to be seeing clients for CBT, how can I make sure that it is as safe, ethical and effective as possible? This was the main reason for the high levels of supervision in the programme, with trainees being expected to attend at least an hour's supervision between every treatment session, and frequent use of live audio recording of treatments. The evaluation was promising in this regard, with trainees indicating that their levels of competence had increased significantly over the course of the programme. With hindsight, however, should the evaluation be repeated, a number of changes would be made. First the trainee self-evaluation of competence made in the study was post hoc; due to the evaluation beginning after the majority of the trainees had completed the programme. In future evaluations, these would be supplemented by pre training ratings in order to allow true pre/post measures to be taken. Secondly service outcomes, and client experience questionnaires would be included in the evaluation, so as to provide and more varied external measure of trainee competence, which in itself provided a number of challenges.

Assessment of Competence

As discussed in Chapter 1, the definition and measurement of competence in psychotherapy is one that remains a frequent subject of discussion (Barber et al., 2007; Kaslow et al., 2007; Kaslow et al., 2009). Whilst it does not benefit the reader to repeat those arguments here, there were particular issues with regard to the assessment of competence in this chapter. The assessment of competence is complicated when one begins to consider the context in which it is being measured (Barber et al.,

2007). The level of competence required by a first year core trainee in psychiatry (CT1) for example, is very different to that which would be expected of a newly qualified psychotherapist. This raised a conundrum in the development of the training course. The most commonly used competency assessment in CBT, the CTS-R (Blackburn et al., 2001) was designed to measure the minimum competence required by a newly qualified CBT therapist, but as stated previously, this was not the level of competence required by CT1s, nor were the resources available to train them to this level. Additionally, whilst the broad factors measured in the CTS-R were appropriate for measuring the skills of trainees, the scale (a 1-6 Likert type scale, in which a score of 3 represents the minimum competency required by a psychotherapist) was considered to be too restrictive at its lower end to be used as a measurement tool for novice trainees. Finally, the CTS-R was designed to measure a snapshot of therapy, with the evaluation of competence being based on a single treatment session. This neither seemed a reasonable measure of competence for the CT1 trainees, given their lack of experience and training, nor did it correspond with the measurement tools required by the RCPsych. Both the Structured Assessment of Psychotherapy Expertise (SAPE) (Royal College of Psychiatrists, 2015, as cited in Awal, 2016) and the Psychotherapy Assessment of Clinical Expertise (PACE) (Royal College of Psychiatrists, 2015, as cited in Awal, 2016) (both provided in the Appendix E) are designed to measure broad clinical competences across a range of psychotherapies and as such, utilise non therapy specific questions, such as "Management of the ending of treatment" (Awal, 2016, p.9) and "Develop empathic and responsive relationship with patient" (Awal, 2016, p.11), lacking many CBT specific competencies. Thankfully a marking criterion was available for the SAPE (see appendix E) which offered some guidance, and the author used competency criteria in CBT based on those provided by Roth and Pilling (2008a) in the assessment, but even with this, the assessments of competence were often subjective, relying primarily on the experience and judgement of the marker. As such the assessment of competence took three forms; ongoing assessment of therapy audio, constructive use of supervision, and a semi structured interview based on the format of the PACE and SAPE evaluations. There is considerable scope however, for refining this process in future training programs.

Chapter 5: Critical reflection on a Structured Self Development Programme and its applicability to an experienced CBT therapist

Chapter 5 (the Report of Professional Practice) was in some ways the most surprising of all the studies in this portfolio, in that it was the most difficult for me to complete personally and had the greatest perceived impact on me as an individual. I had previously been in two minds about the methodological approach to this study, initially considering a first person action research (FPA) approach (Marshall, 2012), which may have taken a more personal approach to the process involved in undertaking the SPSR programme. However, I decided on a reflective topical autobiographical (RTA) (Johnstone, 1999) approach, which focused more on direct evaluation of my recorded experiences. Whilst this study was primarily experiential, it was important that measurement of competence was also included, as "self-reflection and self-assessment are key components of the assessment of competence" (Kaslow et al., 2007). In doing so I had considered a pre/post investigation of treatment outcomes for clients whom I had seen during the period, but given my primarily leadership role, and consequent small caseload there was not enough power to make a meaningful analysis.

Reflections on the PhD in Professional Practice as a whole

As discussed, the PhD in Professional Practice follows a structured format, designed to enable participants to undertake the programme in their work environment, whilst at the same time bringing both psychological and research thinking to bear on their professional field. Based on my experience, this has a number of advantages and disadvantages in comparison with a more traditional single strand PhD, in which a single research focus is explored in greater depth. When I first considered undertaking a PhD my goal was to develop a single, easy to use questionnaire that would predict who CBT was most suitable for, and had I followed a traditional PhD model this would have been my focus. However, this was not possible in the current structure, and the fact that the CBT-Suits, in this study, did not offer increased predictive validity to that provided by initial symptom severity meant that the hoped for advances to screening and assessment in service were not possible. What I

discovered instead though was of potentially greater value to the service that I lead. The format of the PhD in professional practice enabled me to take a big picture view of the field of bringing research to bear in CBT services, helping me understand that there is no single solution to improving therapy delivery and outcomes, rather a number of smaller micro changes are likely to be necessary on an evolving basis. The practical focus of the thesis has had two main effects, first it has highlighted the difficulties inherent in implementing research and evaluation in a busy clinical team, particularly one in which the majority of staff have had little or no research training. This had led to the implementation of a joint Research Lead role in our service, headed by me and one of the service managers who also has research experience. Through this we aim to put into place structures to support research and evaluation in service, with a view to supporting clinicians to produce studies suitable for submission to peer reviewed journals, benefitting service users, staff and other services by disseminating best practice. Secondly learning from the studies conducted during the programme has led to the integration of research methods into my own practice, as well as the delivery of services by my team. This has resulted in a number of improvements, a feat that is unlikely to have occurred as effectively under a traditional PhD programme. The most notable of these improvements have been the changes to the core psychiatry training programme made following the service evaluation in Chapter 4. As a result of feedback from the evaluation, and reviews of the literature, the identification of clients for trainees has now been brought under the auspices of the IAPT service. This has made it easier for trainees to find clients of a suitable complexity for their stage of learning, led to improved clinical accountability, as all trainees are treating clients open to the same service, and enabled the use of IAPT outcome measures (including patient experience questionnaires (National Collaborating Centre for Mental Health, 2019) in the assessment of trainee competence. Knowledge gained in Chapters 2, 3 and 5 is also being used to develop practical applications in service. Following my experiences undertaking the CPD programme in Chapter 5, an SPSR based staff support and development plan is being formalised for staff identified as consistently struggling to meet their therapy targets. If this proves effective after evaluation it will be offered to other services nationwide. Learning from Chapters 2 and 3 is being put into practice in a different way. First, the lack of predictive validity of the CBT-Suits in the study setting has led to a cessation of, what had been a plan

to integrate its use into the service assessment process. Secondly the identification of factors predicting outcomes in the literature review has been integrated into the supervision process for CBT therapists. This has been of particular use when therapy is not proceeding as expected as the supervisor is able to help the therapist to reflect on factors that might be contributing to the lack of improvement, helping to identify potential blocks in therapy.

The programme has also helped me to lead the development of a stronger research ethic my team. This has been demonstrated in improvements in evaluations of treatment interventions (which are now always considered prior to undertaking a new project), and through close collaboration with the Trust Research and Development (R&D) Team. As a consequence of the latter, the service has now hosted a number of external research programmes, for which I act as on-site lead. It has also led to the implementation of a pioneering a research assistant placement programme, in which staff from the R&D team are embedded in our service. In this way embedded assistants are able to provide improved research support to the team, and benefit from the opportunity to observe and support clinicians in their work. This programme has been extremely successful, with all participants going on to further training posts on either clinical psychology or IAPT training programmes.

Conclusion

CBT as a psychotherapy has been shown to be effective for a range of disorders (Roth & Fonagy, 2006) and across many cultures (Hays, 2014). A range of factors have been identified that may correlate with treatment outcomes and the quality of service delivery, whether they relate to the individual nature of the client attending for therapy, or the competence of the therapist providing the treatment. However, very little is known about how to make use of this knowledge in a clinical setting, for the benefit of individuals attending for therapy. This thesis has sought to integrate psychological and research principles with practical service provision in an attempt to go some way to resolve this.

This thesis offers a number of contributions to the fields of both psychology and professional practice. Section 1 offers an in depth review existing research into client psychological and attitudinal

factors that may predict outcomes in CBT for anxiety and depression. It also adds to the evidence for the factor structure of the CBT-Suits (McLellan et al. 2016), when investigated in a clinical IAPT population. It has also demonstrated that there is no current evidence (based on the research presented here) for the implementation of the CBT-Suits into service delivery in an IAPT setting.

Section 2 demonstrates two applications for potentially improving the quality of training and development for novice and experienced therapists in a clinical setting. Specifically, Chapter 4 offers an evaluation of a bespoke CBT training programme for junior doctors training under the Royal College of Psychiatry core training programme. The evaluation adds to the knowledge base for novice training provision and offers a bespoke evaluation tool for future training programmes, the Experiences of CBT Training and Supervision Questionnaire. Chapter 5 adds to the knowledge base for continuing practice development of CBT therapists, by investigating not only the benefits, but also the challenges associated with implementing a structured Self Practice and Self Reflection programme for an individual working in an NHS service. It offers advice and guidance to other services and practitioners considering engaging in such a programme, though does not seek to make generalizable claims given that it is based on the experience of one practitioner.

It is recommended that further research into the practical applications of the predictors of outcome for CBT in clinical services be undertaken, in order that the wealth of scientific research in the field may be made more available for the betterment of service users.

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Appendices

Appendix A: Suitability for CBT Questionnaire

Participant Initials…… Participant ID (IAPTUS No):……..

Previous Experience of CBT

Have you ever had psychological therapy or counselling before? If you have please indicate below the types of therapy you have had (you may tick more than one).

CBT	○	Psychoanalysis or Psychodynamic Therapy	○
Counselling	○	Art Therapy	○
Family or Systemic Therapy	○	Yes but I don't remember what it was called	○
Cognitive Analytic Therapy (CAT)	○	Other (Please State below)	○
Drama Therapy	○		

CBT-Suitability Scale (CBT-SUITS)

Read each statement and select the option that indicates how much you BELIEVE that the statement is true of you. Mark the response that reflects what you actually believe, not what you might like to believe. There are NO right or wrong answers. Do not spend too long on any statement, but mark the first response that comes to you.

Respond to items according to the following rating scale.

1 = Strongly Disagree, 2 = Disagree, 3 = Neither Disagree nor Agree, 4 = Agree, 5 = Strongly Agree

		1	2	3	4	5
1	If I change the way I think my emotions would be different	○	○	○	○	○
2	If I change the way I think I would behave differently	○	○	○	○	○
3	I put my feelings into words	○	○	○	○	○
4	I am able to be really aware of how I am feeling	○	○	○	○	○
5	I put my thoughts into words	○	○	○	○	○
6	I go and face up to things that are difficult	○	○	○	○	○
7	I can change the way I feel about things by changing the way I think about them	○	○	○	○	○
8	The way I think about something influences what I do about it	○	○	○	○	○
9	I identify my emotions	○	○	○	○	○
10	I can change what I do in a situation by changing the way I think about it	○	○	○	○	○
11	When good or bad events happen to me I get a chance to learn something	○	○	○	○	○
12	I learn from what I do	○	○	○	○	○
13	Even though trying new things is difficult for me, it means things change for the better	○	○	○	○	○

Appendix B: Information Forms

(Provided on headed paper from participating service)

Information Sheet.

Who does CBT work for? A validation of CBT-Suitability Scale (CBT-SUITS)

Hello. My name is Dan Brown and I am the Clinical Lead for Mind Matters Surrey. I am also studying for a PhD at Canterbury Christ Church University.

I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you. Talk to others about the study if you wish. (Part 1 tells you the purpose of this study and what will be asked of you if you take part. Part 2 gives you more detailed information about the conduct of the study).

Summary

In this research study we will use information from you in the form of a short 14 question questionnaire and information that you share with Mind Matters Surrey as part of your treatment, such as routine questionnaires and demographic information. We will only use information that we need for the research study **and we will not make use of information that you discuss with you therapist as part of your treatment**. We will let very few people know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

At the end of the study we will save some of the data in case we need to check it or for future research.

We will make sure no-one can work out who you are from the reports we write.

The following information tells you more about this.

Part 1

What is the purpose of the study?

The purpose of this study is to investigate who Cognitive Behavioural Therapy (CBT) is likely to help the most. Another researcher has developed a short questionnaire that might help us to find this out and we would like your help to discover if this works for people who receive CBT from this service. If we are successful, this could be helpful in making sure that people receive the service most suited to their needs.

Why have I been invited?

As you have been referred (or have referred yourself) for CBT from our service your views are especially important to us.

Do I have to take part?

It is up to you to decide to join the study. If you agree to take part, we will ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive in any way.

What will I be asked to do?
You will be asked to complete a short, 14-question, multiple-choice questionnaire about your opinions related to your upcoming therapy. The questions are not expected to be intrusive nor will you be asked to disclose any personal details about your reasons for coming to therapy. This should take no more than 5 minutes of your time. We will also ask for your permission to access your therapy records so that we can gather information about you (e.g. your age, gender, marital status and diagnosis) and the numerical results of other questionnaires your therapist will ask you to complete as a routine part of your therapy. We will not use this permission to look at personal information that you have told your therapist.

If you would like to complete this questionnaire online you can do so by using the following link (link to be added after amendment agreed)

What are the possible disadvantages and risks of taking part?
The questionnaire is brief and should only take a few minutes of your time. You will also be asked to complete a brief consent form if you agree to participate. If you decide to participate the questions that you will be asked to answer are similar to those that would routinely be asked in therapy and will only take a few minutes of your time. Neither your decision about whether or not to apply nor any answers you may give will affect your treatment in any way.

What are the possible benefits of taking part?
This study will not affect the service you receive from us. However it will give you the opportunity to contribute to our understanding of who benefits most from CBT and improve the way we offer this form of psychological therapy to people in the future.

This completes part 1. *If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.*

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?
Your participation is only expected to take about five minutes of your time, but if you change your mind you are free to stop at any time. You will be able to withdraw your data from the study up to the time when the data analysis is conducted.

What if there is a problem? / Complaints
If you have a concern about any aspect of this study, you can ask to speak to me and I will do my best to address your concerns at CBTSUITS@gmail.com If you remain dissatisfied, and wish to complain formally, you can do this by contacting Professor Margie Callanan, Director, Salomons Centre for Applied Psychology – margie.callanan@canterbury.ac.uk, tel: 01227 927 094 or Robert Melville Canterbury Christ Church University Data Protection officer at E-mail: dp.officer@canterbury.ac.uk. If you are not happy with their response or believe they are processing your data in a way that is not right or lawful, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113).

How will we use information about you?
We will need to use information from you and from your medical records for this research project.
This information will include your

- NHS number and IAPTUS number (the confidential number used to identify you by the participating service)

- Name and contact details
- Demographic information collected by the participating service
- Your responses to the 14 question CBT-suits study questionnaire
- Information routinely collected by the participating service as part of your treatment, such as questionnaires or number of sessions attended.
- **We will not make use of personal information that you discuss with your therapist.**

People will use this information to do the research or to check your records to make sure that the research is being done properly.
People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.
Once we have finished the study, we will keep some of the data so we can check the results. **We will write our reports in a way that no-one can work out that you took part in the study**.

Will information from or about me from taking part in the study be kept confidential?
All information which is collected from you over the course of the research will be kept strictly confidential, unless we identify something that makes us think that you or someone else might be at risk of serious harm. However, as we are only gathering demographic and numerical information we do not expect this to occur.

What will happen to the results of the research study?
The results of this study will be used to help us find out who CBT and counselling are most useful for. We aim to publish these results in a scientific journal so that others can benefit from what we are doing. You will not be identified in any report or publication. If you would to be sent a copy of the study's results once it has been completed, please email us at CBTSUITS@gmail.com

Who is organising and funding the research?
This research is being organised and funded in collaboration between Surrey and Borders NHS Foundation Trust and Canterbury Christ Church University.

Who has reviewed the study?
The study has been reviewed and approved by a research review panel at Canterbury Christ Church University. All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests.

Further information and contact details
If you would like to speak to me and find out more about the study or if you have questions about it, please contact me (Daniel Brown) at CBTSUITS@gmail.com. Please note I can only answer questions regarding the research not your individual therapy or mental health. Questions related to these issues should be directed to your therapist or providing service. Alternatively you can find out more about how we use your information at www.hra.nhs.uk/information-about-patients/

Further information on the Health Research Authority Guidelines for using patient data can be found on their website at the following address

https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/data-protection-and-information-governance/gdpr-guidance/templates/template-wording-for-generic-information-document/

This questionnaire should only be completed once by any participant.

Appendix C: Consent Form

(Provided on headed paper from participating service)

IRAS Project ID: **224572**

Participant Study Identification Number (to be completed by the chief investigator):

_____

Participant name and D.O.B: _____

CONSENT FORM

Title of Project: Who does CBT work for? A validation of CBT-Suitability Scale (CBT-SUITS)

Name of Researcher: Daniel Brown

Please initial box

1. I confirm that I have read and understand the information sheet dated 7th February 2020 (version 2.9) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason [without my medical care or legal rights being affected].	☐
3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by the lead supervisor [Dr Fergal Jones]. I give permission for this individual to have access to my data. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from Surrey and Borders NHS Foundation Trust, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐
4. I agree to my clinical record being looked at by the research team in order to access the information detailed in the information sheet.	☐
5. I agree to take part in the above study.	☐

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

Please mark here if you would like a copy of this signed form ☐

Appendix D: Relevant Core competencies in full

Intended learning outcome 3

Demonstrate the ability to recommend relevant investigation and treatment in the context of the clinical management plan. This will include the ability to develop and document an investigation plan including appropriate medical, laboratory, radiological and psychological investigations and then to construct a comprehensive treatment plan addressing biological, psychological and socio-cultural domains

Intended learning outcome 5

Based on the full psychiatric assessment, demonstrate the ability to conduct therapeutic interviews; that is to collect and use clinically relevant material. The doctor will also demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions

Intended learning outcome 8

Use effective communication with patients, relatives and colleagues. This includes the ability to conduct interviews in a manner that facilitates information gathering and the formation of therapeutic alliances

Intended learning outcome 19

To develop reflective practice including self reflection as an essential element of safe and effective psychiatric clinical practice. (Royal College of Psychiatrists, 2015, pp.37-38)

Appendix E: SAPE and PACE Forms

SAPE

	Unacceptable	Much work to be done	Borderline	Satisfactory	Accomplished	Unable to comment
Attitude towards patient						
Understand rationale of treatment						
Provide working formulation of patient's difficulties						
Develop empathic and responsive relationship with patient						
Establishing frame for treatment						
Use of therapeutic techniques						
Monitor impact of therapy						
Ending treatment						
Use of supervision						
Documentation						

(Awal, 2016, p.9)

PACE

	Unacceptable	Much work to be	Borderline	Satisfactory	Accomplished	Unable to comment
Attitude towards patient and development of an empathic relationship						
Understand of the rationale of treatment and ability to provide a working formulation						
Establishing frame for treatment and noticing challenges to this						
Use of therapeutic techniques and monitoring the impact of these						
Management of the ending of treatment						
Use of supervision						
Quality of written summary in conveying key points						

Adapted from (Awal, 2016, p.11)

SAPE Scoring Guidelines

	Unacceptable (score: 1)	Much work to be done (score: 2)	Borderline (score: 3)	Satisfactory (score: 4)	Accomplished (score: 5 or 6)
1.Attitude towards patient	Derogatory, intrusive or disrespectful	Often makes unjustified assumptions	Some difficulties in appreciating patient's position.	Respectful and non-judgmental	Informed by realistic but positive view of patient's potential
2 Understand rationale of treatment	Cannot explain rationale of treatment	Confused about key differences between therapeutic approaches	Still unsure of how therapy would help patient	Correctly explains basic principles of approach	Recognises how recommended actions lead to therapeutic change
3. Provide working formulation of patient's difficulties	Minimal understanding of what formulation is or no attempt to produce one	Formulation is attempted but significantly incomplete or inaccurate	Formulation lacks at least one important component.	Adequate account of predisposition to, precipitation and maintenance of problems	Formulation is cogent, personalised and theoretically sound
4. Develop empathic and responsive relationship with patient	Little or no sense of patient's feelings or perspective	Working relationship is limited by lack of rapport, interest or understanding	Relationship is often sound but also lapses through therapist's uneven attunement.	Earns patient's trust and confidence from ability to listen and appreciate their feelings	Developed capacity to feel and imagine events from patient's perspective.
5. Establishing frame for treatment	Behaves as if in another setting entirely, eg. talking with a mate; leading an interrogation.	Repeatedly fails to protect setting, keep to time or confuses patient by behaviour towards them	Occasionally fails to maintain setting appropriately.	Manages setting, time, and personal boundaries consistently	Optimises working collaboration by adjusting approach to patient
6. Use of therapeutic techniques	Actions in sessions bear no relation to patient's needs	Attempts at intervention are often clumsy or inappropriate	Interventions vary considerably in execution and success	Well chosen interventions are usually carried out thoughtfully and competently	Interventions are sensitively timed and phrased and linked to positive change
7. Monitor impact of therapy	Repeatedly unable to recognise positive or negative effects when these occur	Limited insight into how patient is being affected by the therapeutic sessions and attendant risks	Evident blind spots in assessments of impact on patient	Describes impact of therapy on patient comprehensively and accurately	Aware of interrelationship between different aspects of change during treatment
8. Ending treatment	Abandons patient without warning, or is unable to let patient go.	Little attention is paid to impact of ending, whether planned or patient leaves early.	Ending is considered, but perfunctorily or at unsuitable moments in the treatment	Patient is prepared for ending of treatment and its consequences are anticipated	Patient helped to continue to develop after cessation of treatment
9. Use of supervision	Misses several sessions without explanation or is very cynical.	Guarded and uninvolved or too dominant in discussion. Fails to grasp what is being conveyed.	Shows capacity to use supervision but this remains inconsistent.	Attends regularly, participates honestly and openly in discussion, uses advice received.	Allies sensitivity with creativity in reflections about the therapy
10. Documentation.	Records (notes and/or letters) are seriously incomplete, inaccurate or misleading	Records omit key events in treatment; summary excessively generalised or uninformative	Records are often competent but incomplete	Record of treatment sessions is focused and clear; final summary /letter apt and comprehensive	Records resembles those of a more experienced therapist

Awal, 2016, p10

Appendix F: Information and Consent Form

Experiences of CBT Training and Supervision Questionnaire

Information and consent form

Dear Colleague.

I hope you are well and your training progresses as you hoped.

As you may be aware I am currently undertaking an evaluation of the teaching and supervision that CT1 and 2 grade Psychiatry trainees receive(d) during their CBT short case, both as part of my ongoing PhD. and as an evaluation of your experiences of training within the Trust.

As we worked together on your CBT case I wondered if you would be so kind as to help me and the Trust by completing the attached "Experiences of CBT Training and Supervision Questionnaire".

The questionnaire is designed to explore how effective the teaching and supervision you received were in helping you to develop your CBT and relational skills.

It is entirely voluntary and your answers will be anonymised by a third person so that I will not be able to link any comments with any particular individual. It can be completed in Word and does not need to be printed.

The questionnaire contains both graded and free answer sections. During the free answer sections please try to write a few lines if appropriate as this will help greatly in the qualitative component of our analysis.

I would also like to utilise the feedback questionnaires that you completed at the end of our work together in my write up (these will also be anonymised) and the assessments of your work that I completed.

It you decide to help by completing the questionnaire please just complete it in word and email it to **XXXXXXXXX** who has kindly agreed to collate and anonymise your response. He has been cc'd into this email.

By responding you will be giving consent for your answers to be used in an anonymised form as part of the Trust evaluation of the training and supervision you received, as part of my PhD project and (if appropriate) in articles submitted for publication in appropriate journals.

With many thanks

Appendix G: Experiences of CBT Training and Supervision Questionnaire

Respondee identifier: (For anonymization, please leave blank)

Experiences of CBT Training and Supervision Questionnaire

Age: Gender:

Dear Colleague.

In preparation for and during your CBT (CT1) Short Case you received a range of training and supervision types. This questionnaire is designed to explore how effective these methods were in helping you to develop your CBT and relational skills.

Please identify which types of training and supervision you received for your CBT Short case. (delete as required)

1) Taught Lectures/workshops on CBT provided by the Medical School (14 Hours) **Yes/No**
2) Taught Lectures/workshops on CBT provided by the Trust (6 hours) **Yes/No**
3) 1:1 or Group supervision focusing on CBT Skills, formulation and interventions (approx. 1.5 hours per week during case totalling 15-24 hours. **Yes/No**
4) Other (Please state)……

How long ago did you complete your CBT Short Case? (mark with an **x**)

1) 0-3 months ago □
2) 4-6 months ago □
3) 7-12 months ago □
4) Longer than 12 months ago □

What if any experience of CBT did you have before your CT1 year?
Have you had any access to CBT Training/Supervision since the completion of your short case? **Yes/No** If yes please describe (Duration/Title)

With hindsight (where appropriate) Please indicate from 1-10, your assessment of your skills/knowledge in each area, where 1=very poor and 10=very good.				
		Before your case?	Immediately after your case?	The present time?
1.	Knowledge of basic principles of CBT and rationale for treatment			
2.	Knowledge of common cognitive biases relevant to CBT			
3.	Knowledge of the role of safety seeking behaviours			
4.	Ability to explain and demonstrate rationale for CBT to clients			
5.	Ability to structure sessions			

6.	Ability to use measures and self-monitoring to guide therapy and to monitor outcome			
7.	Ability to formulate and use this inform treatment			
8.	Capacity to implement CBT in a manner consonant with its underlying philosophy			
9.	Capacity to select and apply most appropriate BT & CBT method			
10.	Ability to ask questions, listen and reflect with clients utilising guided discovery principles and Socratic method.			
11.	Ability to make use of supervision as a tool for reflection and for improving practice.			
12.	Ability to reflect on the skills and knowledge learned and apply them to your own life?			

13. Please **rate** the following aspects of your training/supervision in terms of the quality of provision and how important it was in the development of your CBT competencies (knowledge and skills).

Please indicate from 1-10 with 1 being very poor quality/importance and 10 being very high quality/important			
Aspect of Training	**Quality**	**Importance (knowledge)**	**Importance (Skills)**
Formal CBT teaching			
Specialist CBT supervision			
Supervisory Relationship			
Practical work with clients			
Self-Practice and Reflection			
Do you have any reflections on the above?			

14. What, if any, challenges did you experience during your during your CBT short case?

15. What if anything helped you overcome these challenges?

16. With hindsight was there anything you would have liked to have changed or added to the training/supervision you received for your CBT short case?

17. Is there anything else you would like to feed back about your experience of your CBT short case?

Appendix H: Coding Chart

Participants giving responses relating to each category and sub category			
Category	Sub Category	Mentioned By	Total responses
Good Quality Supervision		A,B,D,E,F,G,I,J,K	9
	Good Quality	A,B,D,E,F,G,I,J,K	9
	Supervisors skill/knowledge	A,B,G,J	4
	Supervisors availability	A,G,H,I,K	5
	Supportive	F,G,I,J,K	5
	Supervisory Relationship	A,B,F,G,I,J	6
	Freedom to ask questions/express worries	A,F,I	3
Structural/process components of Supervision			5
	Group supervision format	F	1
	peer support	F	1
	Audio Recording (positive)	F,I	2
	Flexibility in approach to treatment	F,G,I,J	4

Quality of teaching		B,D,E,I	4
Self-Practice/Self Reflection		B,D,E,I	4
Practical Work		B,I	2
Challenges		A,B,E,F,H,I,J,K	9
	Challenges: Patient non-attendance/Drop out	A,I,J	3
	Challenges: Client non completion of homework	I	1
	Challenges: Trainees perception of knowledge/skills/confidence	B,F,K	3
	Challenges: Uncertainty of direction of therapy	E	1
	Challenges: Structure and content		1
	Challenges: Managing Risk	F	1
	Challenges: Client specialist needs	J	1
	Challenges moving away from medical model	H	
Improvement	No Improvement needed	A,B,D,E,J	5

	Improvement recommended: delay in starting programme	F	1 (of 3)
	Improvement recommended: pre-training discussions with former trainees	F	1(of 3)
	Improvement recommended: pre-training observations of therapists	K	1(of 3)
	Improvement recommended: Access to cases	F	1(of 3)
	Improvement recommended: More live supervision	I	1(of 3)
Perceived benefits of programme			5
	Training has enabled changes to Practice	B,G,I,J	4
	Training has improved Skills	F,G,I,J	4
Positive overall experiences of training			6
	Generally valuable	B,D,E,F,G,I	6
	Compares positively with training in other Trusts	F	1

Enjoyable	E,F,G	3				

Appendix I: Busyness, stress, confidence, and time spent on SPSR

On a Scale of 1-6 Rate	Busyness	Stress at work	Confidence in therapy	Confidence in Leadership	Ability to manage stress	Time spent on SPSR
18/12/20	50	5	5	4	5	180
05/12/20	50	5	4	4	5	120
28/11/20	40	5	5	4	5	180
21/11/2020	40	6	5	4	4	180
14/11/20	50	6	5	4	5	180
29/08/20	30	4	5	4	3	180
22/08/20	60	5	5	4	4	45
15/08/20	40	5	5	4	4	120
08/08/20	40	4	5	4	3	120
18/07/20	50	4	5	5	4	45
11/07/20	50	4	4	4	3	60
04/07/20	30	3	4	4	2	120
27/06/20	50	5	3	3	4	120