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Conflicts of Identity – How Counsellors Practice CBT 5 Years Post Qualification

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Abstract: Cognitive Behaviour therapy (CBT) relies on homogenous practice for it's evidence base. However training to an accreditable standard in the UK requires 3 years of "core professional" training in addition to 1 years CBT training for IAPT (Improving Access to Psychological Therapy, trained for primary care cases only) and 2 years for more complex roles. The core professional training has unique aspects which may differ between professional groups (Nursing, Counselling, Occupational Therapy, etc) have varied ideological standpoints and practice rituals, and have the potential to conflict with aspects of CBT. This study asks the question "How do (BACP accreditable) Counsellors and psychotherapists (Hereafter counsellors) in High Intensity IAPT roles practice CBT"? and achieves this through analysis of a focus group of 5 counsellors with at least 3 years CBT experience using a thematic analysis methodology. Five themes were identified - processes in transition, ongoing processes reconciling roles, Features retained from counselling practice, Features changed from counselling practice, and features of CBT resisted and not adopted. Results suggest a broad adaptation to CBT with some aspects of counselling (Responsiveness to the client, knowing the whole of the client) emphasised more or differently to conventional views on CBT Practice. Counsellors do not adopt, or try to avoid adopting, some of the more positivist aspects of CBT, and this remains an ongoing source of conflict in the application of CBT. Implications: Counsellors do not fully conform to the CBT model of practice. Further research is necessary to establish whether this affects outcomes.

Keywords: Counselling, CBT, Transition, Role Conflict

1. Introduction

The advent of Improving Access to Psychological therapies (IAPT) in the United Kingdom has enabled evidence-based therapies to be provided to 75,000 patients per year, and has trained about 6,000 "High intensity therapists" (with provision for 3,000 more, NHS 2016) to provide Cognitive Behavioural Therapy, or CBT in the first instance, at a primary care level [1]. The CBT aspect of the training is undertaken in one year, although accreditation relies on 3 years prior training in a "core profession" (including counselling) or equivalent. Counsellors represent about 10% of BABCP[1] accredited therapists.

CBT is a family of therapies that use cognitions and behaviours to change emotions, adopts a present focus, takes a structured approach including targets and use of measurement, is collaborative, and is based on formulation and evidence [2, 3]. By contrast, most counselling interventions emphasise greater responsiveness to the client's current needs, a greater focus on emotions and autonomy, and less positivist aspects as a general rule. CBT relies on homogenised practice for it's evidence base [4], and yet the majority or the training (i.e. the core profession) has the potential to differ between core professions, and even conflict with CBT in both values and practice.

The relationship between generic counselling and psychotherapy and CBT is complex. CBT based skills often form part of a counsellor's repertoire, sometimes adopted within an integrative model, and sometimes as a more eclectic "cut and paste" approach, and there is clearly integration of CBT ideas into generic approaches (See [5]).

The relationship of a purer CBT model with counselling and psychotherapy is more complex. Some areas of counselling and psychotherapy have expressed concern about the recent

[1] British Association for Behavioural and Cognitive Psychotherapies.

rise of CBT, and although the strength of opinions vary, it appears this is important within counselling culture, possibly due to a high emphasis on autonomy compared with CBT (E.g. [6] P. 85). There appear to be 2 principal objections: that CBT is facilitating state control of psychotherapy, and that it promotes homogeneity and damages a tradition of diversity, "dumbing down" the therapy process [7, 8].

This paper reports on a follow-up focus group of 5 former integrative counsellors and / or psychotherapists (Hereafter Counsellors) currently practicing as High Intensity (IAPT) CBT therapists. 5-6 years after completing IAPT training, with the aim to describe and analyse how and what they are practicing in their current roles. This has implications for the evidence base of CBT, but also it enables readers to observe some features considered core to counselling and psychotherapy from those who have experienced the role but are now outside of the profession. This area is largely unresearched, although there is some research on counsellor identity development [9]) and counselling roles and values [10]. Some features believed to define counselling include fostering growth and potential [11], maintenance of a "gut" response as opposed to a rational one when with the client [12], parallel process and the conscious use of self [13] and the importance of the therapeutic relationship [14].

2. Method

The research question employed was is "How do Counsellors / Psychotherapists practice CBT in the High intensity role?". The method of analysis used is thematic analysis according to the methodology described by Braun and Clarke {15}. Thematic analysis is a qualitative research method suitable for reporting non-measurable data from the perspective of those experiencing it, often in a narrative form [16], with relatively low levels of interpretation. The research question does not require a complex emphasis, (E.g. such as lived experience, IPA). The version of thematic analysis proposed is factist in if's view of the data, and constructionist in the interpretation process. Constructionism is a form of constructivist learning theory which argues learning new information is best achieved by building together units of information that are tangible [17]. Although frequency of occurrence is a consideration, quality of participants endorsement takes priority, distinguishing in from the Content Analysis [15].

There are a number of advantages of a focus group over Individual interviews. Firstly. It addresses the research question, which is aimed at the level of the group. Also, other group members can comment on contributions by others, sparking original thought and establishing whether a consensus exists. This has the potential to improve confirmability and generalisation of findings, and promote diversity of contributions on the same subject.

2.1. Participants

Counsellors meeting the criteria of being accredited at the time of High Intensity training, and with 3 years post-qualification experience from one NHS trust were invited to participate. All were practicing High intensity therapists and all were BACP accredited at the time of starting IAPT training, with the exception of one who was UKCP registered. The participants' training occurred within 2 institutions and across 2 cohorts. 7 of those initially invited were female, but only females opted in to the focus group. Although this is relatively representative of the counselling profession, the lack of a male participant is acknowledged as a weakness. The age range is 34-55, with a mean of 45.8 and a standard deviation of 8.44.

2.2. Data Collection and Analysis

After the research question had been formulated, ethics permission was obtained from the appropriate university. Ethics permission was not required within the National Health Service, although site specific permission was required through IRAS (Integrated Research Application System), and permission was obtained from the head of service. A pilot interview was conducted with a non-participant meeting the inclusion criteria, and adjustments made to the questions. A gatekeeper within the service was then identified, and the researcher then passed an Introductory letter, Participant Information Sheet, and Consent Form to the gatekeeper who forwarded them to eligible participants within a service of approximately 50 IAPT High Intensity Therapists, including approximately 10 former counsellors. The details of those who consented were provided by the gatekeeper to the researcher.

The interview was recorded and transcribed, with audible features of the data (Laughing, over-talking) also reported to retain context. Recorded data was coded, then categorised into initial themes, initially in the margins to keep the themes as close to the data as possible. The data was then mover initially to separate sheets, then to a card system, in order to make it more manageable. It was then subject to a number of revisions until saturation of the main themes were present in the themes.

2.3. The Researcher's Position in the Research

The researcher has been an accredited Cognitive Behavioural Therapist for over 10 years, and prior to that, a Mental Health Nurse by background. He did not undertake the IAPT training. The presence of a CBT affiliation and the lack of a counselling affiliation is acknowledged, at a formal level, as having the potential to bias the study if counselling and CBT were to conflict. The author kept a journal throughout the study to identify and acknowledge potential biases and conflicts, and one journal entry notes that the author learned CBT in a forensic setting working with complex clients, where a range of therapeutic skills beyond the traditional IAPT skill set and overlapping with counselling skills, were employed by the author. Thus, while not ideologically neutral, a range of influences provides some balance. The literature review was suspended until after the themes had been established, consistent with recommendations such as Braun and Clarke [15], however, with a background in CBT, IAPT, and having

clinically supervised psychotherapists from a range of backgrounds, the author is not value- or knowledge-neutral, but has aspired to be aware of and account for these factors.

2.4. Quality of Research

Trustworthiness of qualitative research needs to be established in order to ensure a quality in areas paralleling validity and reliability in quantitative research [18]. This research is limited by low participant numbers, some homogeneity of the sample (Single workplace), and researcher involvement, and efforts to manage these limitations involve addressing credibility, transferability, and dependability. Credibility of the research is achieved by use of clear, established methods, researcher familiarity with culture, triangulation, clarity on the voluntary nature of the research, peer scrutiny, and a detailed description of the phenomenon. Although iterative questioning was only partially employed, global statements were not taken at face value as some were context specific. The researcher also checked for exceptions to statements where appropriate. The participants were shown the initial findings and invited to comment on them for additional credibility.

Transferability is limited as the participants currently worked for the same institution, although their background experience varies widely – this is acknowledged as a weakness. In order to address dependability, the methodology is described above, and a more detailed methodology is available from the researcher if required**.** The author used a learning journal to explore his reflexive role within the research to ensure confirmability of the research (i.e. that it's authenticity extends beyond the author's own personal view). An example from the journal is provided above.

3. Results

Five themes emerge from the research (Figure 1). Three of these themes, "Retained from Prior training", "Changed practice from prior training" and "Resisted from IAPT training", can be viewed as constructs with relationships to each other in the Venn diagram in Figure 2.

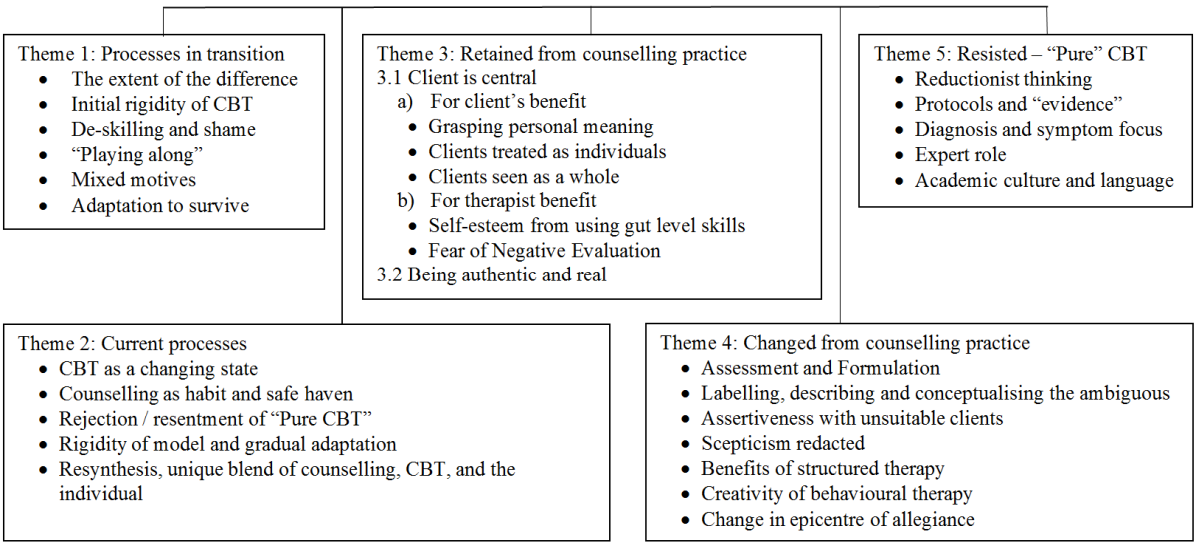

Figure 1. *Overview of counsellors' themes.*

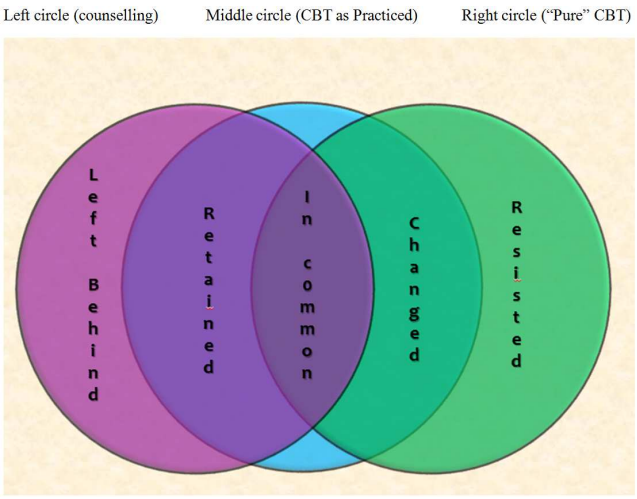

Figure 2. *Counsellors relationship with CBT.*

The other two themes "Processes during transition" and "Process issues in current practice" are more general, Processes during transition describe issues that are raised for counsellors in terms of resolving conflicts during transition, and "Process issues in current practice" describe ongoing tensions reconciling IAPT practice with their own identity and philosophy.

Theme 1: Processes During Transition

The processes in this section describe corroborate related research (E.g. see [19]), and describes the features and processes of reconciling CBT with previous practice during training and immediately afterwards.

The extent of the difference was larger than expected for the majority. There was an unanticipated perceived difference in language, techniques, and autonomy. There is a lack of familiar structures and initial bewilderment. It is difficult to ascertain retrospectively to what extent the perception of the

difference fits with the reality of the difference, but the fact that it was larger than expected is significant:

P4:...at the beginning I felt really disorientated, I couldn't quite get how to hold these counselling and CBT together and I remember walking out going it's not counselling, that's not counselling ...it's something very different. 168-170, 170-1.

Related to this was an expectation of not working rigidly within one model, and the rigidity of expectations from CBT creates a feeling of being constrained in best practice which is disliked by the counsellors. This was reportedly enforced my management, lecturers, and supervisors:

P1:"... the thing I really struggled with at the start was the structure...actually being asked in supervision to drop all my other skills. You know I have to be a CBT practitioner and I have to forget my previous trainings..." 174-5, 178-9.

Counsellors expect to be leading and helping others with generic skills, however their existing skills are in a number of areas considered outmoded, and counsellors not only have to learn new skills, but also unlearn and overcome their investment in their previous skills, which when addressed, activates competency shame in most.

Although there is a general willingness to learn eventually, there are some areas where the counsellor privately disagrees with CBT practice, but plays along in public. These differing views do not appear to reconcile over time. Croft, Currie and Lockett [20] note that some transitioners can fall into a liminal space, neither belonging to one group or another, and this does not necessarily reconcile over time (E.g. a nurse-manager). An example provided by this group is clinical supervision, where there is less emphasis on process and ambiguity in CBT. Counsellors describe it feeling insufficient, but adapt a way of presenting clients which is "playing along" with CBT:

P4:"...how will I present this in supervision, how will I present as a case discussion, what is it that I'm doing with people, am I actually following my role. So that is a conflict for me constantly (Murmurs of agreement from others)" 89-91.

A complexity in the process of transition is that counsellors both aspire to be counsellors and CBT therapists, and assumed that it would be possible to do both comfortably. There is recognition that there are conflicting motives for being attracted to each.

P3: And I chose counselling through passion and I chose CBT for profession so they were very different things when I was trying to work out how to merge those two.

I: Do they both add something?

P3: They do.

I: Is that universal experience? (Generic yes's) 373-8.

The final aspect of the transitional processes is that the process of belonging within CBT and not occupying a liminal space between roles was not chosen but necessitated in order to be accepted by the dominant paradigm, adapting to survive. Counsellors have committed to the process of CBT.

P3: Well I was opposed to it {CBT model}(laughs) even though I opted to do the training, but yes there's a process of change and integration isn't there that happens I mean it has to happen as a matter of surviving really I think. 429-31

Theme 2: Current processes

The category of current processes encompasses ongoing themes related to current work practices of IAPT High Intensity CBT therapists from a counselling background.

The rigidity of the CBT model and gradual adaptation to it bridges from the last category. It is not CBT per se that the counsellors struggle with - one counsellor mentioned similar difficulties with a pure person-centred approach – but the rigidity of application of the model. The counsellors, as they have become increasingly familiar with language and concepts, have been able to integrate those suitable to their philosophy into their practice, and operate more successfully and effectively within a CBT framework.

P4: It's like learning how to drive, you're doing it to pass and then as soon as you pass you start to develop your own way… (over talking), 447-8.

The interviewer noticed that counsellors had become more comfortable with CBT and wondered if CBT itself had changed over this period (See [21]). Counsellors generally felt this to be the case, and mentioned that CBT incorporated broader skills more and this has become more permissible in IAPT and helps the counsellors manage the tension of the role.

P4: I think it just gives permission to know that it's ok to be flexible and CBT's have had to bring in other stuff to make it more workable.

P1 CBT has been changing – that makes it more workable (526-7).

There are also periods where the counsellors revert to counselling practice, although as they become more adept at functioning within CBT, this appears not to be a wilful attempt to avoid practicing CBT, but a residual habit of returning to the familiar:

In the process of adaptation, counsellors bring aspects of their previous practice into their CBT practice, and also bring their therapist and personal selves into the role creating a unique "re-synthesis" of CBT, counselling and the individual. Re-synthesis is a form of transition that blends all the factors together in an original way [22]. When CBT was deemed to be imposed on the identity of the individual it was resisted, but when there was an opportunity to see how it fitted with "individual self" and "counsellor self", it was explored:

P4: It's definitely not like I'm gonna put my counselling head on for ten minutes now and then I might put my CBT therapist head on it's definitely much more integrated…

P5: …interesting it's become more free flowing as well, before it was slightly yes I'm putting my counselling hat on but it seems to just flow automatically, I wouldn't know the distinction myself sometimes. (463-5, 466-8)

Theme 3: "Retained" from Counselling Practice

There is a general theme within this section that counsellors practice a version of CBT that works according to some pre-existing principles and values. As we have noticed, this becomes easier over time, initially through

exposure, and later through familiarity with CBT language and culture.

The most dominant theme was the centrality of the client and the right of the counsellor to have autonomy to respond to the needs of the client. This right is equally applicable to working in a very structured way with the client as responding to emotions, depending on what the client is believed to need in that moment. The centrality of the client is deemed to occur for the clients benefit, but it is also retained for the benefit of the therapist.

Centrality of client – for client benefit

The centrality of the client, and the need to be able to respond to the needs of the client, initially contrasts sharply with an initial view from some counsellors that CBT is "done to" clients, probably derived from protocol-driven research. While there is a recognition that there are a number of factors within CBT, such as formulation and target setting, which personalise the therapy to the client, the notions of fixed expectations of how to respond to clients or guide therapy, and narrow conceptual understandings of the client's world, remain difficult. Counsellors continue to wish develop a deeper understanding of the client in order to truly grasp the Personal meaning of their problems, especially in the early stages of therapy:

P2: I might tend to kind of go with the client obviously and obviously have a CBT framework in my mind but it might be that I use it more eclectically as a toolbox (ums from other participants) and whatever feels pertinent at that time... (32-34)

Although grasping the personal meaning is important, the principle of treating clients as individuals is ethically important, extending from the humanist notion that every individual is unique and has potential (see [23]). There is an ethical block that the degree of personalisation of therapy should be higher than it initially presents in CBT – individualisation is considered more important than conceptualisation:

P5: It's almost like I'd like to enter into their world and see their world from their perspective rather than... try to just fix the symptoms. (19-22)

There is a third related sub-theme, also related to previous counselling practice, and having an ethical component, that clients should be known, understood, and worked with as a whole, not just according to their problems, and not just in the context of pre-recognised frameworks (e.g. formulation).

P*3: ...it feels like the like the whole is more than some of the parts so if you do a five areas model it's almost like waters the…some kind of experience down than when I kind of formulate in that way I lose something. (50-52)*

Centrality of client – personal motivations

The exploration for personal motivations in psychotherapy has been present since Freud [24] and an exploration of the self is fundamental to the role. In the sample, there appear to be two related themes, the first is that use of gut level skills, ability to respond "in the moment" to the client, is highly valued as a personal characteristic by counsellors, and when the practice is not allowed to the same extent in CBT, this is perceived by some counsellors as a form of disenfranchisement. Related to this is that counsellors appear to obtain self-esteem from therapeutic work that is creative and stimulating, even if this is not necessary for client improvement. Just "doing what is necessary" in terms of CBT was actively insufficient for the counsellors at a personal level:

P2: ...I think I'd find work really boring and not very creative if I was this idea about purist and just doing the set third session of GAD and therefore I need to do this, I don't think I could get up in the morning. (459-461)

Fear of Negative Evaluation (FNE) is a concept used in CBT, especially within Social Anxiety Disorder, to describe cognitive contexts where individuals fear being negatively judged by others, often leading to problematic anxiety and shame (E.g. [25]), especially related to performance. In counselling, there are considered to be a range of correct responses to any particular therapeutic scenario, and as a result, there is much less judgement attached to any subsequent discussion of the intervention.

CBT also places greater emphasis on therapist adherence to evidence, through both clinical and management supervision. This greater likelihood of judgement is combined with the fact that, compared with counselling, there are clearer right-wrong interventions, and therefore more likelihood of negative evaluation. It is clear from the interview that keeping the client central protects against the potential for negative evaluation. When the potential for negative evaluation is mandated through adherence to practice protocols, it affects counsellors confidence and quality of intervention:

P4: When I was worried about… is what I'm doing CBT and am I any good at it or actually I think I might be quite bad at it and when I was anxious about those things I think I wasn't giving very good therapy. (276, 277-8)

The other category present in the "Retained" section concerns being authentic and real, communicating to clients their experience, and encouraging clients to do the same. A range of concepts and practice rituals (Diagnosis, models, labels) are deemed to interfere with this process, and therefore authenticity is lessened as a result. This continues to be practiced, and where challenged (E.g. in supervision) it is resisted:

P3: Coming to supervision with a boiling down or a diluted down of something that feels significant, sometimes I don't even know what the words are but something's going on and I need the space in supervision to do that, to have that conversation with other people witnessing it (227-230).

A number of aspects of counselling continue to be practiced despite not being in the CBT mainstream. Although briefly disallowed during training, lower levels of compliance checking and to a certain extent, accommodation by CBT has led to these practices continuing.

P5: ...it's (Counselling) almost like ingrained and you're trying to go against the grain it felt hard, but you had to do this exam, it had to come across as though you're doing

CBT but you can't change the leopards spots… (Participants laugh) (610-615).

Theme 4: "Changed" from counselling practice

This section focuses on areas of practice where counsellors have substituted counselling for CBT. We noted in the previous section that concepts dilute experience for the counsellors leading to some retention of practice. These concepts also assist the counsellor with their therapy, for example in assessment and formulation, where the counsellor faces a dilemma of wanting to explore client emotions, but also containing them. Counsellors appeared to learn that formulation is a way to achieve this, and even though there is some ideological opposition to the principle, counsellors note that achieves their desired outcome for the client:

P1: Yeah for me I think yeah, for me I suppose my assessments are sharper, more focused, (Yes's) it's given me skills and things whereas I suppose our training in counselling's has always been a little bit vague in that… (303-305).

There is a perceived advantage in not conceptualising too early for the counsellors, in order to understand the client's experience authentically. However there are also advantages to this approach. Conceptualisation and labelling are deemed to assist not just CBT, but good client-focused therapy at times, as clients notice that labelling sometimes helps to accurately describe the experience. Note that in the example below, there is also a greater assertiveness when therapy is unlikely to work.

P3: And I probably think I'm better at naming…like when you're working with someone who's really resistant or really kind of challenging in a particular way, … I just might be more forthright about naming that, in a kind way.

P2: I think CBT allows that sort of challenge doesn't it and focus, and that's certainly given me that notion to do that as well and the language which I might not have used in the same way. (Yes's) (321-4, 325-9).

The focus group note scepticism of CBT during training, however after 3-5 years of CBT practice, and in spite of ongoing difficulties with aspects of CBT, this scepticism has been largely redacted. Not only are there considered to be areas of CBT that are largely effective, some of these areas do not conflict with anticipated problems associated with CBT as expected:

P4: I think I've given up the fact that I was really sceptical about CBT and how really effective it is particularly for some of the anxieties, the phobia, standard phobia models, (Yes's) it's amazing the work to do with basic and graded exposure that it produces something really significant and you can talk about it for ages so it's almost like I'd given up that idea about just sitting there and talking about it and I got into the let's plan and do something and it makes all the difference. (330-335)

The quote above also highlights an unexpectedly positive relationship with the more behavioural aspects of the therapy. Behavioural therapy's creative and experiential stance bypasses the issues of reductionism present in cognitive therapy, and it's emotion focus is congruent with counsellors view of themselves (and personal needs) as creative practitioners, with the client at the centre. CBT provides the additional notion that proactivity can also prompt emotional expression and resolution:

P1: …so it's ok to very active isn't it but in counselling we may well have withdrawn from it that CBT can be active.

P5: Go and feed the birds in the park, never mind talking about being frightened of the birds let's go and feed the birds and see what happens. (340-3)

A final notion within the category of "Changed" is that there is a move in epicentre of allegiance (or self-categorisation, [26]) from Counselling to CBT. This is evident in two different ways. The first is that weaknesses in CBT, previously criticised from outside, are acknowledged, but there is a willingness to work from within to address these weaknesses and support and develop CBT. There is also a shift in attribution of areas of conflict, with difficulties that would previously be targeted at CBT are now targeted at the IAPT system, "Pure CBT", or elsewhere.

Theme 5:"Resisted", "Pure" CBT

This section focuses on CBT based principles and practice that are not practiced and actively resisted by clients. CBT is difficult to define, perhaps best thought of on a continuum between being protocol driven and formulation driven (Grant et al 2010). CBT is also becoming broader [21]. In conceptualising CBT for this section, it appears that three different meanings exist concurrently within the transcript:

"Pure"or "Purist" CBT, a term used by the counsellors fifteen times in the interviews, is the highly positivist, highly conceptualised, protocol driven form which was assumed to be the entirety of CBT at the start by many. Although acknowledged as only one aspect of CBT at the time of interview, it is largely resisted ideologically by counsellors.

"IAPT" CBT. CBT as initially taught, and as commonly practiced in IAPT in the early stages of training, inappropriate for complex cases and does not include broader therapeutic skills.

"Broad church" CBT incorporating a broader range of therapeutic principles (Including counselling) and applications beyond IAPT and is more formulation driven. Counsellors have become increasingly aware of this as their CBT base strengthens.

This section highlights a rejection of "pure CBT", the first aspect of which is reductionist thinking, viewed as a linear approach to reasoning which misses important data out. The "one size fits all" idea is also rejected, i.e. that there is only one correct way to approach a problem for all people at all times:

P1: When I felt it was prescriptive it didn't feel helpful anymore because it's like oh god I've got to work like this 218-219.

Practice protocols and the evidence base also present ideological difficulties for counsellors. Homogeneity was necessary to establish the evidence base, but they also restrict aspects of practice such as receptivity that are valued by counsellors. Counsellors are trained to notice

uniqueness and diversity in their clients [27], and may have an attentional bias towards noticing when clients don't fit into models or protocols. There is not an outright rejection of the evidence base from counsellors, but there is a reluctance to accept one approach to evidence (positivism) as the only approach, and likewise one approach to resolving a therapeutic issue:

P5: There's a book, there's the workbook, just go and do it, there's no room, no space for individuality.

P4: Why can't that be CCBT (Computerised CBT) put the words in the box, challenge their thoughts, and just go?

P3: Yeah Yeah. (All in sarcastic tone) 477-9, 481-3.

The evidence base is dependent on the diagnosis, which categorises therapeutic problems according to symptoms. This has some awkwardness with CBT, which is more interested in treating maintenance factors than symptoms, often the product of the problem that the problem itself. Counsellors go further in that the wholist ideology means that the notion of treating a symptom, and also the notion of focusing on alleviating deficit rather than facilitating growth leads to a general rejection of this aspect of CBT.

P1: …I was just going to say does the person become a symptom (generic yeah's) and actually that isn't…certainly how I want to work and so it is taking into account things like context isn't it, the bigger picture, the emotions. (79-81)

The creation of concepts and protocols promotes the medicalised idea of expert knowledge and expert role – the clinician delivers the therapy to the client. This is present in CBT at times, although a collaborative approach is more typical. Counsellors describe a client or collaborative focus in therapy. The notion of the therapist being an expert appears to undermine the idea of an equal or client focused relationship. Even though these tensions also exist within CBT, they appear to have more of an ethical / ideological component amongst counsellors, explaining a greater reluctance to perform the expert role:

P3: actually I struggle with those things within offering CBT because there's a sense that I have to be the expert and actually that's (laughs)…doesn't sit very well… (263-5)

The idea of the expert role is not just problematic in the therapy room. As a result of the evidence base and the overall approach to knowledge and practice, there is perceived to be more of an Academic expert hierarchy within the CBT profession itself, and this is also rejected by the counsellors. This rejection appears to be because academia is perceived to be valued more highly than practice, but also because there is a requirement that practitioners have to follow academics models and protocols:

P1: The research...is about massaging the so called experts' egos. (577, 578-9)

The knock-on effect of following the experts, models, and prococols, from the counsellors' perspective, is to be inauthentic and not client centred, which, as we have already noted, are unacceptable to the counsellors. One counsellor described being much more comfortable when she reduced the amount of theoretical language in-session.

4. Discussion

The role that counsellors adopt in the high intensity role is complex and multi-faceted. Aspects of both counselling and CBT are both adopted in some areas and deliberately not practiced in others. Croft Currie and Lockett's [20] example of a liminal role seems to fit the counsellor-high intensity therapist.

The transition process is clearly difficult for the counsellors involving a loss of knowledge, role, and identity with the range and depth of these losses. The imposed process of the IAPT version of CBT reinforces some prejudices towards CBT from the counsellors, although these subside after training. The initial loss and bewilderment mirrors Robinson et Al's [28] experience of Mental Health Nurses transitioning to IAPT, and, Bennett-Levy and Beedie's [29] assertion that CBT training is personally challenging regardless of core profession.

The most significant feature retained from counselling is the centrality of the client. This appears to have been identified with very highly, and retained into the High Intensity role. This appears to be consistent with the need for both counsellor and client autonomy, discussed earlier. It is perhaps surprising that other features of counselling with some differentiation from CBT, such as an emphasis on emotions and the role of the core conditions, are not more present within the sample. While CBT is broadly practiced, interventions tend to be filtered through the lens of the centrality of the client. The need to be independent practitioners, especially from politicised delivery through organisations such as the National Institute for Clinical Excellence (United Kingdom), has been an important debate within the psychotherapy community, and many of the counsellors reconcile CBT with maintaining autonomy.

A fairly wide range of CBT practices are adopted, but only in the context that they are beneficial to the client or reinforce counselling practice. Creative aspects of behavioural therapy are deemed effective beneficial to the client, but also maintain a focus on emotions – an approach preferred by the counsellor. A further example is formulation, which is noted to contain the client and enhance engagement. The counsellors are then able to process the changes as development of their core profession rather than loss.

CBT has a positivist history is terms of symptom focus, model development, efficacy research, and protocol drivers. Counsellors actively resist these processes, but affiliate with CBT, acknowledging the positivist features as weaknesses. This is consistent with cognitive dissonance theory, which proposes that when an individual is required to act in a way different to their values, then the values are re-scripted to align in some way with the behaviour [30, 31]. The counsellor tries to change these processes from within, and no longer projects blame at CBT generally, but targets IAPT or CBT academics instead.

5. Conclusion

The practice of Counsellors employed as CBT therapists is complex but not entirely typical of CBT according to the evidence base. CBT is delivered in a unique way, with aspects of counselling retained in preference to CBT, and aspects of CBT resisted. This was initially influenced by a difficult transition process, but these issues remain significant post qualification.

Implications for the research occur at a number of levels. It is clear that counsellors do not practice prototypically according to the evidence base. Further research is required as to whether this affects client outcomes in any way. The research also clarifies cultural aspects of counselling that remain and are considered core to the practitioner even when working outside of the model, and also aspects of CBT that are resisted.

There may also be implications for pluralist working. If transitions between psychotherapy models are incomplete and affected by partisan perspectives as appears to be the case from this research, this may impact upon the quality of therapy, with transitions being inevitable as fashions and demand changes. This would suggest that therapies should at least recognise common factors, and there is an argument for including training on integrating new learning into existing models as they are taught. Alternatively, a reduction in "schoolism" in favour of a more pluralist approach to Psychotherapy in accordance with the evidence [32] may increase therapist flexibility in the transition process. Although much research has been conducted into making CBT and other psychotherapy training effective (E.g. see [33]), attention has not been given to training support for those with core professional backgrounds that have the potential to complicate transition, and more research is required in this area.

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References

[1] Clark, D. M. (2011) 'Implementing NICE Guidelines for the Psychological Treatment of Depression and Anxiety Disorders: The IAPT Experience.'. *International Review of Psychiatry* 23, 375-384.

[2] Westbrook, D., Kennerley, H. and Kirk, J., (2007). An Introduction to CBT: Skills and Applications.

[3] Grant, A., Townend, M., Mulhern, R. and Short, N., (2010). *Cognitive Behavioural therapy in mental health care*. Sage.

[4] Hawton, K. E., Salkovskis, P. M., Kirk, J. E., and Clark, D. M. (1989) *Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide.*: Oxford University Press.

[5] Hollanders, H (1999) 'Eclecticism / Integration – Historical Developments'. Pp 1-31 IN: Palmer, S. and Woolfe, R. eds., 1999. *Integrative and eclectic counselling and psychotherapy*. Sage.

[6] Bond, T. (2015) *Standards and Ethics for Counselling in Action*.: Sage.

[7] Mollon, P. (2009). The NICE guidelines are misleading, unscientific, and potentially impede good psychological care and help. *Psychodynamic Practice*, *15* (1), 9-24.

[8] Leader, D. (2010) 'Therapy shows us life is not neat or safe. So why judge it by those criteria'? The Guardian 9/12/2010 Available at: https://www.theguardian.com/commentisfree/2010/dec/09/talking-therapy-regulation-judgment accessed 2/9/2015

[9] Moss, J. M., Gibson, D. M. and Dollarhide, C. T., (2014). 'Professional identity development: A grounded theory of transformational tasks of counselors'. *Journal of Counseling & Development*, *92* (1), pp. 3-12.

[10] Gazzola, N., & David Smith, J. (2007). Who do we think we are? A survey of counsellors in Canada. *International Journal for the Advancement of Counselling*, *29* (2), 97-110.

[11] Ivey, A. E. and Van Hesteren, F. (1990) 'Counseling and Development:"No One can do it all, but it all Needs to be done"'. *Journal of Counseling & Development* 68 (5), 534-536.

[12] Henderson, P. (2010) 'The Pull to Academic Assessment... "the Wrong Hoops' about Assessment of Written Work in Counsellor Training", April Therapy Today'. *Therapy Today* 21 (4), 43-43.

[13] Reupert, A. (2006) 'The Counsellor's Self in Therapy - in Inevitable Presence'. *International Journal for the Advancement of Counselling* 28 (1), 95-105.

[14] Bor, R., Miller, R., Gill, S., & Evans, A. (2008). *Counselling in health care settings: A handbook for practitioners*. Macmillan International Higher Education.

[15] Braun, V. and Clarke, V. (2006) 'Using Thematic Analysis in Psychology'. *Qualitative Research in Psychology* 3 (2), 77-101.

[16] Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & health sciences*, *15* (3), 398-405.

[17] Ackermann E., Gauntlett, D., and Weckstrom, C. (2009). 'Defining Systematic Creativity', LEGO Learning Institute.

[18] Shenton, A. K. (2004) 'Strategies for ensuring trustworthiness in qualitative research projects', *Education for information,* 22, 63-75.

[19] Ashforth, B. (2000) 'Role Transitions in Organizational Life: An Identity-Based Perspectiv*e'*. Routledge.

[20] Croft, C., Currie, G., and Lockett, A. (2015) 'Broken 'two-way Windows'? an Exploration of Professional Hybrids'. *Public Administration* 93 (2), 380-394.

[21] Winter, D. A. (2008) Cognitive Behaviour Therapy: from Rationalism to Constructivism Ch. 11 Pp 137-145 IN: House, R. and Loewenthal, D. eds., 2008. *Against and for CBT: Towards a constructive dialogue?*. Pccs Books.

[22] Seelye, N. and Wasilewski, H. (1979) 'Historical Development of Multicultural Education'. *Multicultural Education: A Cross-Cultural Training Approach*, 47-61.

[23] Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of consulting psychology*, *21* (2), 95.

[24] Freud, S. (1974) 'Letter from Sigmund Freud to CG Jung, June 6, 1907'. in *The Freud/Jung Letters: The Correspondence between Sigmund Freud and CG Jung*. ed. by Anon: Princeton: Princeton Univ. Press, 58-62.

[25] Clark, D. M. and Wells, A. (1995) 'A Cognitive Model of Social Phobia'. *Social Phobia: Diagnosis, Assessment, and Treatment* 41 (68), 00022-00023.

[26] Reid, S. A. and Hogg, M. A. (2005) 'Uncertainty Reduction, Self-Enhancement, and Ingroup Identification'. *Personality & Social Psychology Bulletin* 31 (6), 804-817.

[27] Gibson, D. M., Dollarhide, C. T., and Moss, J. M. (2010) 'Professional Identity Development: A Grounded Theory of Transformational Tasks of New Counselors'. *Counselor Education and Supervision* 50 (1), 21.

[28] Robinson, S., Kellett, S., King, I. and Keating, V., (2012). 'Role transition from mental health nurse to IAPT high intensity psychological therapist'. *Behavioural and cognitive psychotherapy*, *40* (3), 351-366.

[29] Bennett-Levy, J. and Beedie, A., (2007). 'The ups and downs of cognitive therapy training: What happens to trainees' perception of their competence during a cognitive therapy training course?'. *Behavioural and Cognitive Psychotherapy*, *35* (01), pp. 61-75.

[30] Festinger, L., (1962). 'A theory of cognitive dissonance (Vol. 2)'. Stanford University Press.

[31] Cooper, J. (2007).' Cognitive dissonance: 50 years of a classic theory'. Sage.

[32] Cooper, M. and McLeod, J., (2007). 'A pluralistic framework for counselling and psychotherapy: Implications for research'. *Counselling and Psychotherapy Research*, *7* (3), pp. 135-143.

[33] Bennett-Levy, J., McManus, F., Westling, B. E., & Fennell, M. (2009). Acquiring and refining CBT skills and competencies: which training methods are perceived to be most effective?. *Behavioural and cognitive Psychotherapy*, *37* (5), 571-583.