Doctoral Thesis

Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

Exploring Real-World Psychotherapy Processes and Endings: A Meta-Ethnography and Reflexive Thematic Analysis

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Word Count

Section	Main Text	Appendices, including References, Figures and Tables	Total
Abstract	282	-	282
Literature Review	7646	11577	19,223
Empirical Paper	7996	8171	16,167
Critical Appraisal	3986	901	4887
Ethics Section	3439	-	3439
Total	23,349	20,649	43,998

Thesis Abstract

Much literature explores psychotherapy processes from a theoretical lens or within heavily controlled environments. This thesis deepens understanding by examining the perspectives of those directly involved in psychotherapy - service users and therapists - to provide evidence grounded in real-world experiences.

Section One presents a meta-ethnography of first-hand accounts from service users who experienced an ending from individual psychotherapy. Four databases were searched (PsycINFO, MEDLINE, EMBASE, Web of Science), resulting in 16 included papers. Two over-arching themes resulted from the synthesis, each with various sub-themes: Cohesion within the Ending Process, and Personal Agency within the Ending. Service users placed high importance on their perceptions of interactions with their therapists, and the amount of control they felt they had over the ending.

Section Two reports a Reflexive Thematic Analysis, exploring what therapists who deliver CBT for depression believe creates change. It aimed to understand how CBT is applied in real-world practice. Twelve participants took part in semi-structured interviews. Three themes were identified: “There’s some real power in that relationship that you’ve got with them”, “They’re buying what you’re selling”, and “Giving them that bit of insight […] ‘What do I need now to help me navigate it a little bit better”. The analysis yielded that therapists actively attempt to facilitate perceptions of themselves for clients as empathetic, honest, and hopeful. It explores how therapists balance CBT fidelity with their own beliefs about how their therapeutic approach creates change and clients’ needs.

Section Three provides a critical appraisal which focuses on the process of conducting both the review and research paper. It discusses reflexivity, limitations of the papers, areas for future research, and the impact of my learning on my clinical practice.

Declaration

This thesis records research undertaken for the Doctorate in Clinical Psychology at Lancaster University. The work presented here is the author's own, except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

Name: Olivia Johnson

Signature*: O. Johnson*

Date: 28th May 2025

Acknowledgements

Firstly, I'd like to thank the participants who took part in the empirical study. Thanks so much for finding time to spend with me. I'm appreciative that I got to speak with therapists who are so passionate about supporting people through challenging times in their lives. It was a privilege to speak with you all, I learnt so much from the experience which I hope to take onwards into my own practice.

I'm extremely grateful to have worked on this project with the support of two amazing supervisors. James, thanks for all your help. I have learnt so much from you during our supervisions, and we've managed to laugh along the way. Thanks for inspiring me and encouraging me when we've come across tricky bits, helping me to navigate through. I'll miss our supervisions a lot. Rob, thanks for sharing your absolute wealth of knowledge with me! You've always found time to help me when I've needed support and I'm so grateful. This project would have been so much more difficult without two warm and kind supervisors.

Thanks to all my friends for supporting me and being sounding boards throughout this process. I feel so lucky to have such wonderful people in my life. Thanks to my partner, Harry. You've done so much to help me when things have felt tough. Your love, understanding and patience has been incredible. Thanks for looking after me on nights where I've worked late and needed some sustenance, company, and a laugh! You've always been there to listen to me, and I can't tell you how excited I am to start our next chapter together.

The biggest of thanks to my Mum and Dad, who truly are my heart. The love and support you have given me throughout my life is beyond words, and I wouldn't have made it to this point in my career without it. The three of us get through anything together and I am so grateful to both of you. Thanks for always having faith in my abilities and encouraging me to chase things to achieve my goals.

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Section One: Systematic Literature Review

Exploring service users' experiences of ending from an individual psychotherapy – a Meta-Ethnography

Word count (excluding references, tables and appendices): 7646

Abstract: 203

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Abstract

Purpose: Endings are considered a distinct phase of a psychological intervention. Guidelines and theoretical models are limited in their application to clinical practice, as real-world endings contain nuances such as service constraints and service user-initiated terminations. Although research surrounding service user's perspectives of endings offer rich narratives, these accounts are highly context-specific and have limited applicability beyond their original settings. This review aims to synthesise first-hand accounts of service users' experiences to create an overarching understanding of endings in a variety of contexts.

Methods: Systematic searching of PsycINFO, MEDLINE, EMBASE, and Web of Science databases took place to identify relevant studies. Studies' qualities were appraised using the CASP tool, and a meta-ethnography approach was applied to synthesise the data. **Results:** Sixteen studies (total = 451 participants) met the inclusion criteria. The synthesis yielded two constructs: Cohesion within the Ending Process, and Personal Agency within the Ending.

Conclusions: Service users' perceptions of unity with their therapist during the ending, alongside their free will to affect the ending, were the most salient internal processes connected to psychotherapy endings. The findings hold clinical relevance to therapists, and services, exemplifying that positive endings are experienced when service users feel control and choice are given to them.

Introduction

Context

There is recognition, within psychotherapy literature and clinical practice, that endings denote a distinct phase of therapy; significantly different from work completed within the assessment, formulation, and intervention phases (Schlesinger, 2013; Bhatia & Gelso, 2017). Governing bodies offer guidance for clinicians to manage endings; therapy should cease when service users no longer require the intervention (American Psychological Association (APA), 2016) and therapists should provide advanced notice to service users about ending therapy (British Association for Counselling and Psychotherapy (BACP), 2018). However, clinical practice events demonstrate psychotherapy often concludes in ways guidelines do not anticipate. Service users may decide to end therapy themselves (Westmacott et al., 2010), or therapists may decide to end treatment despite service users' wish to continue (Lee et al., 2023). Real-world endings often reflect the existing gap between guidelines and practice in psychotherapy (Fernández-Álvarez et al., 2020).

Practitioners cite organisational constraints, and differing service user needs, can serve as barriers to applying guidelines within clinical practice (Bell et al., 2022). In relation to therapy endings, time-limited interventions have become the central tenant of publicly funded services such as the NHS (Mukuria et al., 2013). Whilst guidelines recommend that termination should happen when service users no longer require an intervention (APA, 2016), service users and clinicians report time-limited interventions often conclude before service users are ready to end (McPherson et al., 2020; Vernon & Schweitzer, 2023). Abrupt and unplanned endings are commonplace, only 38% of service users were defined as completing a course of psychotherapy within NHS Talking Therapies services in 2021/22

(NHS Digital, 2022). Factors associated with abrupt endings are dissatisfaction with therapy, progress withdrawal (Ghaemian et al., 2020), and complex relational needs (Zavlis, 2023). Service users report feeling abandoned by services as a result, which they attribute to clinical decline (Montiel et al., 2022), loss of therapeutic gain and symptom recurrence (Edlund et al., 2002). It is therefore evident that guidelines do not appear to be well matched to the wide range of clinical settings in which endings occur (Schwartz-Mette & Rowan, 2024).

Models of Endings

Freud (1937) expressed his belief that psychotherapy endings should occur when all unconscious conflicts are resolved, a threshold he contended many service users would never attain. In his model, psychoanalysts alone judged if a case could, or could not, reach a conclusion. This stance is incongruent with the high propensity of endings initiated by service users, or services, rather than therapists (Hanevik et al., 2023; Connell et al., 2006). Freud's stance predates the collaborative models of many modern practices, in which therapy direction and goals may be mutually agreed by service users and therapists (Kazantzis et al., 2012). Additionally, short-term interventions and disorder-specific protocols are typically brought to an end when mutually agreed goals are attained (Jacob et al., 2022; Franklin et al., 2024), not when therapists declare all unconscious conflicts have been resolved.

Balint's (1950) Termination-As-Loss model conceptualises psychotherapy endings as a significant loss, akin to bereavement, for the therapeutic dyad. The Termination-as-Transformation model (Quintana, 1993) recasts the experience of loss as a potential catalyst for growth and increased autonomy. Empirical evidence does support the notion that

endings can be perceived by both service users and therapists as transformative (Webb et al., 2019; Fragkiadaki & Strauss, 2012). This framework however assumes an optimal psychotherapy conclusion, characterised by a mutually agreed upon ending with satisfactory therapy outcomes. Endings from psychotherapy which has not produced satisfactory outcomes can lead to self-criticism for service users, alongside feelings of sadness and abandonment (Radcliffe et al., 2018; Bear et al., 2022). External factors such as financial pressures and unstable life circumstances may also force premature psychotherapy endings (Knizley, 2016; O'Keefee et al., 2019). When therapists initiate endings that go against service users' wishes they can experience disappointment, and a sense of disconnection resulting from feeling their needs have been misunderstood (Lee et al., 2023). Consequently, Quintana's (1993) model is restricted in its application to the nuanced complexities captured by empirical investigation of real-world psychotherapy endings.

In addition to theoretical models, different therapeutic disciplines shape psychotherapy endings to their models of distress (Greenberg, 2002; Goldfried, 2002). Common elements, such as reviewing therapeutic gains and consolidation of work completed, appear across disciplines (Norcross et al., 2017). Yet, each employs modality-specific frameworks such as exchanging goodbye letters in Cognitive Analytic Therapy (CAT; Ryle et al., 1990; Kerr, 2002) or relapse prevention work in Cognitive Behavioural Therapy (Beck, 1967; Beck, 2020). Service users report such techniques as helpful; goodbye letters, for instance, aid processing the therapeutic relationship's end (Hamill et al., 2008). Nevertheless, systematic research integrating service users' experiences of modality-specific practices remains limited.

Research Exploring Real-world Endings from Psychotherapy

Quantitative research examining real-world psychotherapy terminations has identified client groups at greater risk of dropping out, including those experiencing depression and those identifying as sexual minorities (Anderson et al., 2019). Additionally, it has consolidated knowledge regarding the significance of a positive therapeutic alliance for therapy retention (Westmacott et al., 2010). While these findings highlight important factors in retaining psychotherapy service users, they reveal little about the experience of endings. Qualitative exploration has yielded richer accounts of psychotherapy endings however these have mainly considered therapists' perspectives (Dunn et al., 2024; Vernon & Schweitzer, 2023; Fortune et al., 1992). These investigations expose theoretical blind spots, describing endings shaped by unsuccessful outcomes or externally imposed time limits. Therapists report frustration and guilt when their therapy does not produce successful outcomes, relating these feelings to perceived expectations that therapy should 'cure' service users (Bear et al., 2022). Therapists report often feeling unable to create impactful changes in time-limited interventions, experiencing the ending as premature and externally driven (Vernon & Schweitzer, 2023). Service users' and therapists' perceptions on why psychotherapy has ended are often misaligned; therapists tend to attribute service user drop out to successful outcomes (Todd et al., 2003). Whereas evidence suggests alliance ruptures, practical barriers, and dissatisfaction often underpin service users' decisions (Westmacott et al., 2010). Therapists' experiences of endings should not be assumed to mirror those of service users. Recognising service users as active agents in their therapeutic process, and its outcomes, underscores the importance of research rooted in their own perspectives (Gorlin & Békés, 2021).

A meta-ethnography (Webb et al., 2019) sought to address this gap through synthesising first-hand narratives of service users' psychotherapy endings. It identified three constructs: the anticipation of the ending, service users' desire to be in control, and service users' sense of responsibility to the therapeutic relationship. These constructs demonstrate that person-centred factors, such as striving for control, are more salient for service users than theorised psychological processes depicted by models. The synthesis, however, pooled heterogeneous contexts, including discharge from high-secure hospitals (Madders & George, 2014; Tetley et al., 2011) and step-down from community teams (Cuddeback et al., 2013). It additionally employed broad search terms, which did not include specific therapeutic modalities. Thus, the perceptual subtleties of endings from an individual psychotherapy may have been diluted within the synthesis.

Aim of review

The paper aims to systematically review and synthesise current literature exploring service users' first-hand accounts of experiencing an ending from an individual psychotherapy. To our knowledge, this is the first qualitative review to explore this.

Method

The review protocol was prospectively registered on PROSPERO (reg number: CRD42024588590), accessible via crd.york.ac.uk/PROSPERO/display_record.php?RecordID=588590.

The review followed healthcare focused meta-ethnography guidelines (Sattar et al., 2021) and aimed to align with the ENTREQ Statement (Enhancing transparency in reporting the synthesis of qualitative research; Tong et al., 2012; Appendix B).

Search Strategy

Four databases, PsycINFO, MEDLINE, EMBASE, and Web of Science, were searched in August 2024 following discussion with a subject librarian and informed by Webb et al. (2019). The Sample, Phenomena of Interest, Design, Evaluation, Research type tool (SPIDER; Cooke et al., 2012) was utilised to develop search strings around the core concepts of: 'service users', 'experience', 'psychotherapy', 'endings', and 'qualitative research'. Following Sattar et al. (2021), empirically tested qualitative search strategies were sought (McKibbon et al., 2006) to balance specificity and sensitivity of the search. Free-text and subject-headings terms were used, including specific modalities such as 'Cognitive Analytic Therapy'. The full search strategy can be found in Table 1. To test search effectiveness, six relevant studies from Webb et al. (2019) were seeded into the search, all of which were retrieved.

Inclusion and Exclusion Criteria

Studies were included if they were peer-reviewed articles, available in English, and used qualitative data collection and analysis to report first-hand accounts of service users' experience of ending from an individual psychotherapy.

Exclusion criteria included quantitative designs, non-individual psychotherapies such as group therapies, therapy embedded within broader interventions such as inpatient programmes, counselling interventions, reviews, theses, and dissertations.

Whilst Sattar et al. (2021) advise against including mixed-methods studies in meta-ethnographies, Atkins et al. (2008) suggests allowing mixed methodology, if at least two researchers reach agreement for inclusion of the data. The research team agreed to include mixed-methods papers if they clearly detailed the qualitative analysis procedure and

presented rich first-hand accounts of service users' experiences. Mixed methodology papers retrieved for full text screening were checked for inclusion by the first author and one other member of the research team. Full agreement was ascertained before any mixed methodology papers were included in the review.

Screening and Study Selection

The search returned 6,688 papers, which were imported into EndNote (EndNote Version X9, 2019). Duplicate papers were removed following Bramer et al.'s (2016) guidelines, leaving 4,673 papers. Remaining papers were imported into Rayyan (Ouzzani et al., 2016). The first author screened titles and abstracts, excluding 4,620 papers. An independent reviewer screened 200 records (4.28%) with no discrepancies. Full-text papers were retrieved for the remaining 53 papers; one (Jung et al., 2014) was excluded as it could not be accessed in English. Thirteen papers were reviewed collaboratively by the research team. These papers were selected for full team review because they were either mixed-method studies or focused on premature drop out. This aimed to assess the richness of qualitative methods and the paper's focus on service users' firsthand experiences of ending from therapy. Consensus was reached amongst the research team. Sixteen papers met the full inclusion criteria; Figure 1 presents a PRISMA flow diagram of the selection process. Backwards and forwards citation searches yielded no additional studies.

A mixed-methods study (Roe et al., 2006a) included by Webb et al. (2019), was excluded. The study's qualitative findings were based on responses from two open-ended questionnaire items and lacked participant quotes. Therefore, it did not meet the review's criteria for first-hand accounts.

Quality rating system

The Critical Appraisal Skills Program (CASP; 2018) checklist for qualitative research was utilised to assess studies quality. The checklist includes ten items, of which eight are analytical. The questions serve to appraise the information quality provided by studies for various aspects of its design and write up procedures, such as sampling strategy and data analysis. Each question was scored using Duggleby et al.'s (2010) three-point scale: 1 (limited justification), 2 (moderate justification), and 3 (extensively addressed), for a total possible score of 24. This scoring method has been applied in other meta-ethnographies (McDonnell et al., 2023; Cooper et al., 2020). The first author appraised all included studies, and an independent reviewer appraised four (25%). Scores differed by no more than one point, discrepancies were discussed and the first author determined final scores. This approach was adopted by O'Connor et al., (2021). Scores ranged from 14-23, no studies were excluded based on quality. As advised by Sattar et al. (2017), the highest-scoring study (Olivera et al., 2017) was selected as the 'index study'. This paper was the first in which concepts were extracted and thereby guided the synthesis process.

Meta-ethnography approach

Meta-ethnographic synthesis was conducted using the seven-phase framework for healthcare research, adapted by Sattar et al. (2021) from Noblit & Hare (1988). Meta-ethnography was selected to allow conceptual reinterpretation of existing research exploring service users' internal experiences of ending therapy.

The initial two phases, "Getting started" and "Deciding what is relevant to the initial interest", are described in the Introduction and Search Strategy sections of this paper. Following this, the "Reading the studies" phase was conducted. The first author read all

studies in detail to identify key concepts and themes. A study characteristics table (Table 2) summarised studies context. A data extraction table (Table 4) recorded first-order (participant quotes) and second-order (author interpretations) constructs. Following this, the “Determining how the studies are related” phase was commenced. Studies were compared amongst each other to identify recurring or shared concepts. This iterative process generated thematic clusters labelled with descriptive names (see Figure 2 for an example). In Phase 5, “Translating the studies into one another”, each concept was compared across studies to determine the presence or absence of conceptual parallels, further revising the clusters. Papers were synthesised in descending order of CASP scores, with higher-quality studies exerting more influence on third-order construct development. Author interpretations and translation tables (Appendix C; Table 5) supported the process of translating findings into third-order interpretations.

Reflexivity

Given the interpretative nature of meta-ethnography, it is essential to acknowledge the researchers’ positionality (Creswell & Poth, 2024). The first author has clinical experience within NHS settings as a therapist; they have particular interest in relational models of therapy such as CAT therapy. This interest may sensitise the researcher to relational aspects of psychotherapy endings. The research team are interested in alternative approaches to mental health services, particularly those which focus on the promotion of ceding control to service users (Griffiths et al., 2024) including the decision to end therapy.

These perspectives may have shaped interpretation. To mitigate bias, a third-party colleague was provided with emerging constructs and themes with related participant quotes. They were invited to challenge potential bias derived from the first authors

positionality. Supervision discussions and engagement with relevant literature helped to maintain reflexive awareness throughout the research process.

Findings

Study Characteristics

Sixteen papers were included in the review; Table 2 provides a summary of their characteristics. The studies included a total of 451 participants. Combined, they had a gender split of 61.86% female participants. The studies were predominantly conducted within Western populations. Five studies were conducted within the UK, three studies each were from the US and Norway, two each were completed in Argentina. Iran, Canada, Brazil, and Israel contributed one paper each to the study. Ethnicity was reported in only three of the studies.

Six of the papers solely focused on participants' experiences of therapy endings (Knox et al., 2011; Olivera et al., 2017; Råbu & Haavind, 2018; Råbu et al., 2013; Råbu & Haavind, 2012; Roe et al., 2006b). Four focused on the experiences of individuals who were considered to have dropped out of therapy (Hundt et al., 2020; Jung et al., 2013; Khazaie et al., 2016; Wilson et al., 2004). Four focused on participants' accounts of experiencing specific psychotherapy modalities (Balmain et al., 2021; Bury et al., 2007; Hoskins et al., 2009; Kehle-Forbes et al., 2022). One focused on experience of hindering events in psychotherapy (Burton & Thériault, 2020), and one focused on participants' perceptions of their therapeutic change, reason for consultation, the therapeutic relationship and termination after finishing psychotherapy (Olivera et al., 2013).

Synthesis

The analysis yielded two overarching themes: Cohesion within the Ending Process and Personal Agency within the Ending. Each theme contained various subthemes through which service users' ending experiences can be understood. A summary of which studies contributed to each construct, and sub-theme, is provided by Table 6.

Construct One: Cohesion within the Ending Process

This construct refers to service users' perceptions of alliance between themselves and their therapist in aspects of the therapy ending. It includes service users' perspectives of interpersonal communication within the therapeutic dyad; alongside if the ending aligned with their ideal expectations. Four sub-themes are present within this larger construct: Consensus to End Therapy, Tools and Exchanges to Process the Ending, Unexplained Endings, and Perceived Finality of Termination.

Consensus to End Therapy

This sub-theme relates to service users' perceived agreement within the therapeutic dyad about ending therapy. Regardless of whether the ending was initiated by the service user, therapist, or mutually agreed upon, service users placed significance on their conceptualisation of their therapist's reactions, and if the two parties agreed on the decision.

Service users who introduced the therapy's ending made inferences about their therapists' reactions. Positive experiences were reported when therapists were perceived as agreeable and the process felt unified, for example: "I value it as very positive the fact that I proposed it and she supported the decision" (Olivera et al., 2017). When therapists disagreed with ending therapy, negative experiences were reported: "he didn't take it well

[…] I never went back after that time" (Olivera et al., 2017). Reaching consensus was interpreted by service users as confirmation of therapeutic progress: "If the therapist had been of the opinion that I wasn't finished when I thought I was it would have been disheartening. It was important that he agreed with me" (Råbu et al., 2013). This was perceived similarly when therapists initiated the termination: "That the therapist introduced termination felt like an affirmation that I had managed well and made progress" (Råbu & Haavind, 2018). One paper's findings, (Roe et al., 2006b), appeared to refute the importance of consensus to end, but the person described having "the capacity to cope with the therapist's response" and this gave them a positive ending experience. However, importance was still placed on service users' perception of their therapist's belief in therapeutic change: "I didn't get the response I was hoping for […]. But at least he didn't interpret it as resistance, which was a great relief" (Roe et al., 2006b).

Consensus to end therapy was also related by individuals to feelings of safety and security within the therapeutic dyad. Service users expressed feeling "understood" (Jung et al., 2013) when they believed their therapist supported their wishes, rather than interpreting their therapist's responses as "defensive or argumentative" (Roe et al., 2006b). When one party disagreed with ending, a therapeutic rupture was interpreted by service users. Individuals described feeling "abandoned" (Olivera et al., 2017) when their therapist wished to end and they did not. Service users who introduced the ending, when therapists disagreed, also believed this caused a rupture. They hypothesised that their therapists "didn't like it" (Olivera et al., 2017) and that they experienced a "feeling of rejection due to [my] desire to terminate" (Roe et al., 2006b).

Tools and Exchanges to Process the Ending

Service users described the therapy's ending phase as an adjustment process. They discussed therapeutic tools and interpersonal exchanges during this period which facilitated positive experiences. Practical and emotional forms of support were described as increasing their confidence to adapt to the next steps of life, without therapy and their therapist.

Individuals felt end of therapy letters (Balmain et al., 2021; Hoskins et al., 2019) increased their future hopes, "it did give me a bit of a boost. I was thinking okay I can actually do this I'm going to be okay" (Balmain et al., 2021). Letters were valued as tools which reflected the therapeutic dyad's shared understanding built during the therapy: "A lot of it was about how the therapist understood you and it's quite reassuring to have that as a reminder" (Hoskins et al., 2019). Similarly, reducing session frequency towards the therapy's ending was described as a device which increased autonomy and sensitively managed the end of a significant relationship: "It would have been more difficult if I went there every week and then suddenly should stop. Then I would have felt lonesome" (Råbu et al., 2013). Service users provided with strategies by their therapist to continue after therapy described this to facilitate their self-assurance, "[Therapist] gave me tips on how to carry on with 'home-therapy' which allows me to carry on tackling this eating disorder confidently on my own" (Hoskins et al., 2019).

General discussions of therapeutic progress, and the journey shared by the therapeutic dyad, were also highly valued. These interactions were described as supporting individuals in "getting the hang of" (Knox et al., 2011) the ending. One paper described an individual who felt uncertain about ending therapy, they felt these conversations had encouraged them to recognise their progress and accept the ending: "The reasons she gave were that I had finished my mourning period and was able to sit for exams, that my initial

goals had been fulfilled […]. Then she asked if I agreed, and I did" (Olivera et al., 2017). In some instances, individuals appeared to take the lead in these conversations. Initiating discussions about the positive gains they had made and providing affirmation to their therapists about the value of their work together. Positive experiences were reported when service users felt that space was provided for "collaboration, processing the decision, and allowing time to terminate" (Roe et al., 2006b).

Unexplained Endings

This subtheme refers to the ending experiences of service users who chose not to discuss their intention to end therapy with their therapist, or did not fully disclose their reasons for ending.

Individuals decided not to disclose their reasons for ending therapy with their therapists; instead citing that life circumstances such as unemployment, surgery, or travel plans (Kehle-Forbes et al., 2022; Jung et al., 2013; Råbu & Haavind, 2018) were responsible. These explanations were openly referred to an "excuse" by service users (Kehle-Forbes et al., 2022; Jung et al., 2013), when dissatisfaction with, or ambivalent feelings towards, therapy underpinned their ending decision. Those who decided to not communicate their wish to end therapy at all (Olivera et al., 2017; Wilson & Sperlinger, 2004), similarly expressed this decision was preferable to discussing dissatisfaction with, or difficult feelings relating to, the therapy with their therapists. In hindsight, service users frequently expressed regret or discomfort after deciding to not discuss the ending. They reflected not disclosing their feelings may have disadvantaged them, for example: "There's something very awkward for me in being in a room with an adult man sitting in a chair looking at me because that is a reminder and recapitulation of a prelude to major abuse that occurred in

my life. I suppose I could have expressed it but got away from the general discomfort of that" (Wilson & Sperlinger, 2004). Service users reflected that communicating dissatisfaction may have resulted in better therapeutic outcomes or left them feeling more positively towards the ending: "I could, perhaps, have benefitted from more therapy, for my own sake, but also to […] to act more appropriately, to end therapy in a more proper way." (Råbu & Haavind, 2018).

In contrast, service users who experienced unwanted relational dynamics within their therapeutic dyad did not express regret resulting from not communicating their intentions to end (Olivera et al., 2017; Wilson & Sperlinger, 2004). Service users relayed that not communicating the ending to their therapists allowed them to exert control over unwanted relational dynamics. Individuals, who anticipated their wish to end would lead to disagreement, felt they would ultimately feel compelled to continue: "I also felt that maybe she would say she didn't agree with the decision, and then I would end up agreeing with her to avoid an argument. Then I would end up going out of obligation" (Olivera et al., 2017). The development of romantic feelings towards their therapist could also lead service users to end therapy without communicating the reasons for doing so, "knowing nothing would ever happen" (Wilson & Sperlinger, 2004).

Perceived Finality of Termination

Service users reflected on how likely it was that their therapy, and relationship with their therapist, could be continued or resumed.

Service users who felt "the doors were open" (Olivera et al., 2017) to resume the therapy if required, expressed increased amounts of safety and comfort. The opportunity to recommence continued to be positively perceived, even when individuals were certain they

wanted the therapy to end: “I am glad she supported me. I did not want a long therapy” (Råbu & Haavind, 2018). When returning to therapy was not felt to be an option, individuals reported feeling that “there were additional things to work on” (Roe et al., 2006b). When endings were perceived as final, service users placed focus on unresolved aims and goals as there was not a perception of being able to attend to these at a later stage.

Construct Two: Personal Agency within the Ending

This construct refers to service users’ experiences of themselves as active agents in therapy endings, and their beliefs in their own self-efficacy to create and maintain change. It contains three sub-themes: Accepting Good Enough, Taking a Leap, and Autonomy to End Unhelpful Therapy.

Accepting Good Enough

This sub-theme refers to realisations expressed by service users that they had reached a point of satisfaction with their therapeutic gain and decided to end their therapy.

Individuals’ accounts conveyed a sense of acceptance with therapeutic achievement, resulted in arrival at a point in which “in the end, [they] found it was okay to stop” (Råbu & Haavind, 2018). Service users did not report noticing vast personal changes which led them to feel ready to end, instead a sense of restlessness was conveyed, for example: “I am tired of this, tired of taking the tram [...] to come there for the sessions […] I said to myself, this might be proof of improved health” (Råbu & Haavind, 2018). Service users described wanting to create space for other things in their lives as an indication that it was time to end: “I decided to end therapy because I had been dating someone for the last 8 months, and I felt happy.” (Olivera et al., 2017).

Some accounts contained situations where therapists had disagreed with service users' decision to end, or service users were considered to have dropped out of treatment. These service users felt therapy had become stagnant, which was interpreted as indication that goals had been achieved and therapy could end, for example: "I wanted to talk about three topics and I talked about them and I felt I solved them [...]. Finally, when I decided to terminate therapy, it was my decision, it was a unilateral decision […] I could have been all my life with him, I felt that he was never going to tell me to end therapy" (Olivera et al., 2013). In one paper, where individuals were considered to have dropped out from treatment, service users reported that the therapy experience had resulted in important gains despite their decision to not continue: "Prolonged exposure helped me getting outside the house" (Hundt et al., 2020). These accounts perhaps indicate a mismatch between therapists' expectations of therapeutic gain, and service users' satisfaction with achieving the changes most important for them. Reflecting on the ending led service users to identify growth that they had experienced independently, post-therapy: "I'm glad that I did end when I did coz I've moved on so much since then as well" (Bury et al., 2007).

Taking a Leap

This sub-theme expresses service users' ambivalent feelings towards ending therapy. These narratives described endings as an uncertain situation which simultaneously stirred up feelings of pride, freedom, fear, and discomfort. Individuals described the personal meaning of endings as starting afresh in ambiguous circumstances: "I started getting all panicky coz I come here every single week for months now, and it's gonna be really weird […] how am I going to cope with that. And it was sort of exciting in a way; I'm starting a new life" (Bury et al., 2007). Service users conceptualised ending therapy as a "brave choice"

(Roe et al., 2006b) which increased feelings of self-belief as they had: “taken that step. It proved to me that I was able to move ahead and feel alright” (Råbu & Haavind, 2018). Alongside positive connotations were concerns about navigating the world in the absence of therapy, for example: feeling “scared that something would be left un-therapied” (Knox et al., 2011).

Loss of the therapist was also discussed by service users as evoking ambivalent feelings. Individuals reported experiencing “sorrow and pain” (Roe et al., 2006b) resulting from a sense of dependency on their therapists. The therapeutic relationship was characterised as the “most secure and strong” (Roe et al., 2006b) service users had experienced, and their therapist as “the one person I had actually sustained a relationship in therapy with and I remember coming back and I was upset, I was really upset” (Bury et al., 2007). In addition to the loss of a valuable and cherished relationship, individuals described their worries about what the loss of this relationship may mean for them, for example: “fear that without her [therapist] I will not be able to spread my wings and fly”. In contrast, service users also described feeling a need for independence and self-reliance, for example: “I just didn’t want to become a therapy junkie” (Wilson & Sperlinger, 2004). They described finding themselves preparing for the ending by “pulling away” from their therapist “emotionally”, despite feeling “tremendous affection and gratitude” (Knox et al., 2011) towards them, as a means of coping with upcoming independence.

Autonomy to End Unhelpful Therapy

This subtheme relates to service users’ depiction of their agency to terminate therapy they found to be unhelpful. Service users reported that dissatisfaction with their therapy or therapist resulted in their termination decisions. These factors included, feeling

the therapists did not respect their wishes, believing the therapeutic approach did not meet their needs, and difficulties in the therapeutic relationship.

Service users characterised ending or dropping out of unhelpful therapy as expressions of autonomy enacted in their own best interests. Deciding to end was described as stopping the negative effects of therapy when service users felt their therapists to be misguided, for example: “My therapist started going into areas of my life that I didn’t want to analyse [...] It didn’t end up having a negative effect because I stopped it, I left the therapy” (Olivera et al., 2017). Individuals described exercising their freedom to leave when they were dissatisfied with their therapists’ interpersonal skills: “I felt I was talking to a wall. She sat still, that’s what I felt. She didn’t even look at me, she kept looking down, writing stuff […] I said to myself: What am I doing here, I have nothing to tell this woman, so I didn’t ring the bell and left, I went home” (Olivera et al., 2013). Service users framed these decisions as personally empowering, and protective of their mental health: “Yes, I knew my suicide attempt was wrong; I have had several slips, but I sought out a person who could have helped me, made me feel heard, and understood me. I blame myself enough, but he blamed me and judged me as a sinner. His behaviour was not empathetic, and then I decided to discontinue my psychotherapy sessions” (Khazaie et al., 2016). They felt that no therapy was a better alternative to one they felt to be destructive for them: “found it more distressing to be in therapy with a therapist who was not able to help” (Knox et al., 2011). Unhelpful therapy experiences were characterised by service users as learning opportunities in which they gained clarity about support which would be better suited to them, for example: “They just want to go into the past, but we need or what I need is to cope with what I have right now, and then everyday civilian life, instead of just regressing to the roots” (Hundt et al., 2020).

In contrast, service users who did not decide to end unhelpful therapy expressed feelings of "disappointment because of a lack of progress" (Roe et al., 2006) and feelings of "not arriving anywhere" (Råbu & Haavind, 2018). Their narratives conveyed feelings of idleness as opposed to the essence of agency captured by the experiences of those who ended unhelpful therapy.

Discussion

Summary and Relevance of Findings

To our knowledge, this is the first synthesis exclusively exploring the first-hand accounts of peoples' ending experiences from an individual psychotherapy. It adds to the research base by illuminating shared patterns of meaning across a range of settings and contexts. The synthesis captures the active nature of service users in the ending process, who navigate these situations in dynamic and intentional ways. It yielded humanistic factors (Rogers, 1957; Levitt et al., 2016), such as the amount of personal agency service users perceive they have regarding when and how endings occur. Alongside the significance of how they believe their therapists respond and behave towards them during the ending process.

The synthesis opposes Freud's (1937) depiction of service user's unconscious desires, such as wishes to extend or end therapy, impacting termination. Service users' narratives depicted conscious recognition of their wishes to extend, or end, therapy. The subtheme of 'Perceived Finality of Termination' details service users' reflections, such as feeling therapy could have ended therapy sooner but extending it to maintain the therapeutic relationship. These cognitive processes often informed intentional decisions, exemplified within the subthemes of 'Unexplained Endings', 'Accepting Good Enough', and 'Autonomy to End

Unhelpful Therapy'. Conscious thought proceeded considered decisions to leave therapy. The subtheme of 'Consensus to End Therapy' captured service users wishes for unified termination decisions; more akin to collaborative psychotherapy practices (Kazantzis et al., 2012) than the therapist determined terminations postulated by Freud (1937). However, there appeared to be some conflict within this. Service users placed high importance on their depictions of therapist's agreement with termination; perceiving that agreement reflected good therapeutic progress. It appeared service users held their therapist's view of clinical improvements in high importance, placing them in a position of power regarding their therapeutic progress.

The Termination-As-Loss model (Balint, 1950) has parallels to the synthesis; service users conceptualise their therapists as providing a secure holding environment, akin to secure early attachment figures. They describe feelings of sadness and abandonment, as described by Bear et al (2022), resulting from endings. The subtheme of 'Perceived Finality of Termination' revealed that when endings were perceived as final and non-negotiable, feelings of sadness and grief were prevalent. The synthesis was not able to interpret the findings in relation to whether service users had experienced public or private therapy, nor time-limited or open-ended therapy. However, service users who experienced definitive endings often reported feeling therapy had ended too soon, congruent to the way in which time-limited interventions are perceived by service users (Montiel et al., 2022). These findings parallel therapists' views that time-limited interventions, in public health settings, often do not feel long enough to create impactful change (Bear et al., 2022).

In relation to the Termination-As-Transformation model (Quintana, 1993); this synthesis adds a multifaceted understanding of increased autonomy, independence, and

confidence stipulated by the model. Within the subtheme of 'Accepting Good Enough', service users indicated increased autonomy, independence, and confidence; however, did not depict these changes using evocative, transformative terms. They describe restlessness or feeling that therapy attendance has become unimportant or inconvenient. They concluded that these emotions or cognitions were indicative of clinical improvement, and suggestive that they no longer required therapy. The findings correspond with depictions of endings as transformative (Webb et al., 2019; Fragkiadaki & Strauss, 2011) yet illuminate that transformation processes may be experienced in less poignant manners than described within the model. The subtheme of 'Taking a Leap' provides evidence for both feelings of loss and transformation, service users experienced paradoxical feelings of pride and freedom alongside fear and loss.

The subthemes of 'Autonomy to End Unhelpful Therapy' and 'Unexplained Endings' facilitate understanding, and develops the research base, surrounding premature termination and dropout from treatment. The findings provide contextual insight into quantitative research relating low therapeutic alliance ratings, and dissatisfaction with therapy, to service user-initiated therapy termination (Westmacott & Hunsley, 2010). The subthemes depicted decisions to terminate therapy as autonomous ones, which service users enacted in their own best interests. In some cases, functioning to protect their mental wellbeing. The decision to end an unhelpful therapy was felt by service users to be one of empowerment which allowed for reflection about what support, or approach, they felt would be more appropriate for them. Whilst the findings provide support for the presence of self-blame and criticism when ending unsuccessful therapy (Radcliffe et al., 2018); this synthesis found these feelings occurred when individuals remained in therapy and did not

choose to end it. Feelings of empowerment and self-efficacy were expressed for those who made decisions to leave.

The 'Tools and Exchanges to Process the Ending' subtheme relates to research identifying overlap in the ending practices of therapeutic modalities (Greenberg et al., 2002; Goldfried, 2002). Service users experienced specific tools such as goodbye letters, and non-specific tools such as general discussions of therapeutic gain, positively. They contributed to increased confidence and self-efficacy. Research surrounding service user's perspectives on modality specific ending tools and processes is scarce. However, all tools were described to provide a structure of which to process and finalise the ending, reflective of the findings surrounding goodbye letters in CAT (Hamill et al., 2008).

This study supports and extends the findings of Webb et al. (2019) particularly around endings as a process of growth, the emotional complexity of endings and the loss of the therapeutic relationship. Both reviews highlight the value of preparation for ending and empowerment however, this synthesis deepens understanding by demonstrating how specific techniques, such as reflection of therapeutic gain and revisiting skills, foster service users' confidence and agency.

While Webb et al. (2019) reported that negative emotional responses follow endings where lack of therapeutic progress is experienced, this review offers a more nuanced account. When service users ended unhelpful therapy, this was experienced as a positive and empowering step to protect their wellbeing. In contrast, those who did not end unhelpful therapy described disappointment. Our findings also expand the previous review's findings concerning service users' focus on their therapists' responses to their wish to end.

Service users interpreted therapists' disagreement as a judgment that insufficient therapeutic progress had been made, negatively impacting their ending experiences.

Additionally, this review captures a group less represented in the prior synthesis; those who ended therapy without communication with their therapist. Those who were dissatisfied with the therapeutic approach, or their progress, expressed regret with their management of the ending. They felt that discussing their feelings may have improved the therapy, or the way they felt about the ending. However, when decisions to end arose from difficulties within the therapeutic relationship, silence was experienced as a means of reclaiming control. These findings underscore the complex interplay between agency, relational dynamics and perceptions of therapeutic success in shaping ending experiences.

Strengths and Limitations

The population of the included studies in terms of gender representation appears to be a relative strength of the study. Within NHS Talking Therapies services 64% of referrals are made for women (NHS Digital, 2018). This review included a gender split of 61.86% female. The sample appears to be fairly representative of those accessing NHS Talking Therapy services.

A strength of the review was its application of the ENTREQ Statement (Tong et al., 2012). By aligning the review process with this, the study ensured a high standard of transparency and methodological rigour across synthesis stages. This structured approach enhanced the credibility and reproducibility of the review.

A potential limitation of the review is that 'mixed methods' was not used as a search strategy term. The rationale for this was that the review aimed to include studies where the

qualitative data collection and analysis processes were rigorous and explicit. Robustly designed qualitative research may have been present within literature indexed as mixed methodology in databases, therefore missed by the search. However, this was deemed to be low probability when weighed against the resource cost of including mixed methods within the search strategy.

It was beyond the scope of the review to translate potentially eligible papers. An abstract (Jung et al., 2014) was screened as a potentially relevant text; however, the full text could not be accessed in English. As qualitative research is heavily dependent on the verbatim language of participants (Hill et al., 2022), it was felt inappropriate to access translations independently of translated peer-reviewed articles. However, potentially relevant and insightful data may have been excluded.

The exclusion of firsthand accounts of endings from a counselling intervention is a potential limitation of the review. The research team came to a consensus to exclude counselling studies based on the following rationale: counselling is often more present-focused, and aims to resolve immediate issues, whereas psychotherapy tends to explore underlying patterns, past experiences, and deeper-rooted psychological processes (Osagu & Omolayo, 2013). The research team felt these differences may shape how service users perceived the therapeutic relationship and the ending of the intervention. It was believed that including counselling studies may have introduced heterogeneity, potentially obscuring dynamics relating specifically to psychotherapy endings. However, it is acknowledged that much debate exists within literature regarding the level of concrete distinction between the approaches, with clear elements of overlap existing between the disciplines (Rakovec, 2019).

A limitation of the review is that the therapeutic modalities experienced by participants within the studies could not be consistently identified. As ending practices are influenced by therapist's allegiance to psychological models, ability to consider the therapeutic modality used within the therapy experienced by service users may have been insightful. Similarly, it was not possible to identify if psychotherapy had been publicly or privately accessed. There are notable differences in the mental health care provisions provided in public and private settings (McAndrew et al., 2017); as such the ability to perceive the data in this way may have gleaned nuanced information.

Included studies within the review were mainly completed within Western contexts. Constituting a bias towards the cultural and political frameworks, alongside approaches to psychological therapies and mental health, within the Western world. This may limit the review's findings outside of these frameworks. Proposed aetiologies and treatments for psychological distress vary greatly around the world (Krendl & Pescosolido, 2020). Investigation of how psychotherapy endings are influenced by these factors would be beneficial in identifying commonalities and differences. Ethnicity data was not reported in thirteen of the sixteen studies included in the review. Within the UK, those from the Global Majority are significantly more likely to drop out of psychological interventions than their White counterparts (NHS Race and Health Observatory, 2023). Individuals cite that lack of cultural consideration contributed to their decision to leave NHS Talking Therapy services (Yasmin-Qureshi & Ledwith, 2021). As the ethnic diversity of participants within the synthesised studies is unknown, it is not known if the Global Majority is underrepresented. Thus, the generalisability of these findings to this population cannot be determined.

The CASP scorings for many included studies indicated that researchers had provided little consideration of, or reporting on, reflexivity. This may have resulted in bias in the both the design and application process involved in the studies, impacting on the reliability of the results.

Recommendations and Conclusions

This review may be useful for aiding therapists' understanding of how endings are experienced by their service users. It is known that therapists' and service users' perspectives on why therapy has come to an end are often misaligned (Todd et al., 2003; Westmacott et al., 2010). This synthesis provides an overarching understanding of first-hand accounts, rather than a proposal of potential psychological processes posited by theoretical models. It highlights the need for therapists to approach endings as emotionally significant events, which can impact service users' perceptions of the therapeutic relationship, alongside their sense of therapeutic progress and agency. Ending decisions should be treated as a shared process, in which therapists actively listen to and consider service users' perspectives on readiness to end.

A key implication for clinical practice is the importance of respecting service users' autonomy when they decide to end therapy. The review suggests that service users' decisions are often intentional and informed, whether it results from satisfaction with therapeutic progress, dissatisfaction, or creating space for other life factors. Therapists should be cautious to formulate early terminations as a form of avoidance and instead consider the context of service users' experiences. Those who terminated against the wishes of their therapist reported positive outcomes, indicating they may often be well placed to determine when they have gained all they wish to from therapy. Individuals report being

highly aware of their therapists' responses when they communicate their wish to end, attributing negative responses as a reflection that therapists believe they are not ready. The potential for service users to be negatively impacted by therapists' disagreement with their decision should be held in mind throughout these conversations.

The synthesis has implications for clinicians in aiding their understanding of drop out. A high propensity of endings results from these decisions (Hanevik et al., 2023). These endings may be a proactive stance, taken by service users to advocate for their own wellbeing and make decisions which feel right for them. Therapists should encourage open discussions with service users about dissatisfaction with their therapeutic approach. This may enable them to clarify what support best meets their needs, even if the result of this is for therapy to be discontinued. Framing early withdrawal from treatment as a form of non-compliance may minimise the potential that the decision has been a healthy one from service users' perspectives.

Furthermore, the review identifies relational and structural elements which shape therapy endings. Power imbalance can result from systems where therapy is perceived to have a definitive end date. Therapists can attempt to mitigate the potential negative impact of this by facilitating transparent, open discussions about the ending. Service users reported positive experiences when therapists planned endings, considered the loss of the therapeutic relationship, and reflected on therapeutic progress. Tools such as ending letters, and reduction of session frequency as the end approaches, can provide a sense of security for service users. Where possible, offering flexibility for a follow-up session or re-engagement can promote a sense of security.

Given the significance of the ending phase in psychotherapy, there is a pressing need for further qualitative research that captures the lived experiences of service users. Notably, there is a lack of research focused on endings within NHS services. System constraints such as time-limited models may uniquely impact experiences. Addressing this gap would provide valuable insights to inform service delivery and policy development within public services.

A recommendation for further research is for qualitative literature exploring endings to explicitly detail the following factors: service user demographics, psychotherapy discipline, service factors, and details of which members of the therapeutic dyad initiated the ending. This could reveal how these factors uniquely influence the meaning and impact of endings.

This review demonstrated that service users place high importance on their perceptions of therapists' responses and behaviours during the ending process. Future studies could examine how therapists' behaviours such as emotional responsiveness, validation, and defensiveness impact service users' experiences. Including both the perspective of therapists and service users could help to reveal important relational dynamics to consider for therapy endings. Such research could inform therapist training, promoting practices more attuned to individual needs.

Overall, this synthesis encourages therapists and services to reflect on how their practices contribute to empowering or disempowering ending experiences. Prioritising transparent communication, collaboration, and consideration of service users' choice may result in more meaningful and positive therapy conclusions.

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Tables and Figures

Table 1

The Search Strategies Used for the Four Databases

	Service users	Experience	Psychotherapy	Endings	Qualitative
PsycINFO/ MEDLINE	client* OR patient* OR service user* OR service-user* OR consumer*	perspective* OR attitude* OR experience* OR view* OR understand* OR percept* OR belief* OR account* OR respons* OR evalu* OR idea* OR feel* OR opinion OR idea* OR thought* OR value* OR emot* OR expect* OR “lived	((psychotherapy) OR (DE "Psychotherapy" OR DE "Adlerian Psychotherapy" OR DE "Adolescent Psychotherapy" OR DE "Affirmative Therapy" OR DE "Analytical Psychotherapy" OR DE "Autogenic Training" OR DE "Brief Psychotherapy" OR DE "Brief Relational Therapy" OR DE "Child Psychotherapy" OR DE "Client Centered Therapy" OR DE "Compassion Focused Therapy" OR DE "Couples Therapy" OR DE "Drama Therapy" OR DE "Eclectic Psychotherapy" OR DE "Educational Therapy" OR DE "Emotion Focused Therapy" OR DE "Existential Therapy" OR DE "Experiential Psychotherapy" OR DE "Expressive Psychotherapy" OR DE "Eye Movement	TI (ending* OR ended* OR termination* OR discharg* OR discontin* OR dropout* OR drop-out* OR ((drop*) n3 (out)) OR complet* OR incomplet* OR non-complet* OR attrit* OR compliance* OR non-compliance OR transition* OR (treat* n3 terminat*)) OR AB (ending* OR ended* OR termination* OR discharg* OR discontin*	(DE "Qualitative Method*" OR DE "Focus Group" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Semi-Structured Interview" OR DE "Thematic Analysis") OR TI (focus group* OR qualitative OR ethnograph* OR interview* OR group discussion* OR grounded theory OR interpretative

	experience*”	Desensitization Therapy" OR DE "Feminist Therapy" OR DE "Geriatric Psychotherapy" OR DE "Gestalt Therapy" OR DE "Group Psychotherapy" OR DE "Guided Imagery" OR DE "Humanistic Psychotherapy" OR DE "Hypnotherapy" OR DE "Individual Psychotherapy" OR DE "Insight Therapy" OR DE "Integrative Psychotherapy" OR DE "Interpersonal Psychotherapy" OR DE "Logotherapy" OR DE "Metacognitive Therapy" OR DE "Narrative Therapy" OR DE "Network Therapy" OR DE "Personal Therapy" OR DE "Persuasion Therapy" OR DE "Positive Psychology Therapy" OR DE "Primal Therapy" OR DE "Psychoanalysis" OR DE "Psychodrama" OR DE "Psychodynamic Psychotherapy" OR DE "Psychotherapeutic Counselling" OR DE "Psychotherapeutic Techniques" OR DE "Rational	OR dropout* OR drop-out* OR ((drop*) n3 (out)) OR complet* OR incomplet* OR non-complet* OR attrit* OR compliance* OR non-compliance OR transition* OR (treat* n3 terminat*))	phenomenological analysis OR narrative OR thematic analysis OR discourse analysis) OR AB (focus group* OR qualitative OR ethnograph* OR interview* OR group discussion* OR grounded theory OR interpretative phenomenological analysis OR narrative OR thematic analysis OR discourse analysis)

Emotive Behavior Therapy"
OR DE "Reality Therapy" OR
DE "Relationship Therapy"
OR DE "Solution Focused
Therapy" OR DE "Spiritually
Oriented Therapy" OR DE
"Strategic Therapy" OR DE
"Supportive Psychotherapy"
OR DE "Transactional
Analysis" OR DE “Dialectical
Behavior Therapy” OR DE
“Dialectical Behaviour
Therapy” OR DE “Schema
Therapy” OR DE “Cognitive
Therapy” OR DE “Cognitive
Behavioural Therapy” OR DE
“Cognitive Behavorial
Therapy” OR DE “Acceptance
and Commitment Therapy”
OR DE “CBT” OR DE “DBT” OR
DE “ACT” OR “Art Therapy”
OR DE “Group Therapy” OR
DE “Cognitive Analytic
Therapy” OR DE “CAT
Therapy” OR DE “Solution
Focused Therapy” OR DE
“psychological therapy” OR
DE “psychotherap*” OR DE
“psychoanaly*” OR DE
“psychoeducation” OR DE
“psychological techniques”

			OR DE “group therap*” OR DE “individual therap*”))		
EMBASE	(client* OR patient* OR "service user*" OR "service-user*" OR consumer*).ti,ab.	(perspective* OR attitude* OR experience* OR view* OR understand* OR percept* OR belief* OR account* OR respons* OR evalu* OR idea* OR feel* OR opinion OR thought* OR value* OR emot* OR expect* OR "lived experience*").ti,ab.	exp psychotherapy/ OR (psychotherapy OR "adlerian therapy" OR "brief therapy" OR "client centered therapy" OR "compassion focused therapy" OR "emotion focused therapy" OR "existential therapy" OR "experiential therapy" OR "eye movement desensitization therapy" OR "feminist therapy" OR "gestalt therapy" OR "group therapy" OR "humanistic therapy" OR "interpersonal therapy" OR "narrative therapy" OR "psychodynamic therapy" OR "rational emotive behavior therapy" OR "reality therapy" OR "schema therapy" OR "solution focused therapy" OR "supportive therapy" OR "transactional analysis" OR "cognitive therapy" OR "cognitive behavioral	(ending* OR ended* OR termination* OR discharg* OR discontin* OR dropout* OR "drop-out*" OR (drop* adj3 out) OR complet* OR incomplet* OR "non-complet*" OR attrit* OR compliance* OR "non-compliance" OR transition* OR (treat* adj3 terminat*)).ti,ab.	exp qualitative research/ OR (focus group* OR qualitative OR ethnograph* OR interview* OR "group discussion*" OR "grounded theory" OR "interpretative phenomenological analysis" OR narrative OR "thematic analysis" OR "discourse analysis").ti,ab.

			therapy" OR CBT OR DBT OR ACT OR "acceptance and commitment therapy" OR "psychological therapy" OR psychotherap* OR psychoanaly* OR psychoeducation OR "psychological techniques").ti,ab.		
Web of Science	TS=(client* OR patient* OR "service user*" OR "service-user*" OR consumer*)	TS=(perspective* OR attitude* OR experience* OR view* OR understand* OR percept* OR belief* OR account* OR respons* OR evalu* OR idea* OR feel* OR opinion OR thought* OR value*	TS=(psychotherapy OR "adlerian therapy" OR "brief therapy" OR "client centered therapy" OR "compassion focused therapy" OR "emotion focused therapy" OR "existential therapy" OR "experiential therapy" OR "eye movement desensitization therapy" OR "feminist therapy" OR "gestalt therapy" OR "group therapy" OR "humanistic therapy" OR "interpersonal therapy" OR "narrative therapy" OR "psychodynamic therapy" OR "rational emotive behavior therapy" OR "reality therapy" OR "schema therapy" OR	TS=(ending* OR ended* OR termination* OR discharg* OR discontin* OR dropout* OR "drop-out*" OR (drop* NEAR/3 out) OR complet* OR incomplet* OR "non-complet*" OR attrit* OR compliance* OR "non-compliance" OR transition* OR (treat*	TS=(focus group* OR qualitative OR ethnograph* OR interview* OR "group discussion*" OR "grounded theory" OR "interpretative phenomenological analysis" OR narrative OR "thematic analysis" OR "discourse analysis")

OR emot* OR expect* OR "lived experience*")	"solution focused therapy" OR "supportive therapy" OR "transactional analysis" OR "cognitive therapy" OR "cognitive behavioral therapy" OR CBT OR DBT OR ACT OR "acceptance and commitment therapy" OR "psychological therapy" OR psychotherap* OR psychoanaly* OR psychoeducation OR "psychological techniques")	NEAR/3 terminat*))

Table 2
Study Characteristics for the Review's Included Studies

Author(s) Country, Year	Research Aims	Methodology	Participants	Psychotherapy and Ending Context
Olivera et al. Argentina, 2017	To examine the clients' subjective experiences of therapy termination.	Semi-structured interviews; Consensual Qualitative Research (CQR) analysis.	53 f, 20 m (73) No ethnicity reporting.	Clients who experienced psychotherapy in an outpatient setting. Client-initiated termination, therapist-initiated termination, agreed termination, and disagreed termination.
Hundt et al. United States, 2020	To qualitatively explore reasons for dropout in treatment.	Semi-structured interviews; Grounded Theory.	11 f, 17 m (28) 7 White; 17 African American; 4 Hispanic	Veterans who experienced Cognitive Processing Therapy or Prolonged Exposure Therapy at a PSTD clinic. Participants dropped out of treatment.
Olivera et al. Argentina, 2013	To investigate former client's perception of change, reasons for consultation, therapeutic relationship, and termination.	Semi-structured interviews; CQR.	11 f, 6 m (17) No ethnicity reporting.	Former psychotherapy clients from outpatient therapy settings. Client-initiated termination, therapist-initiated termination, agreed termination, and disagreed termination.

Balmain et al. United Kingdom, 2021	To examine the 'lived experience' of service users who have been retained in a full course of CAT treatment to provide important insights to why CAT seems to be an engaging psychotherapy.	Semi-structured interviews; Interpretative Phenomenological Analysis (IPA).	5 f, 1 m (6) No ethnicity reporting.	Clients of secondary mental health care services who had experienced Cognitive Analytic Therapy (CAT). Participants had been retained for a full course of CAT.
Khazaie et al. Iran, 2016	To qualitatively explore patients' reasons for dropping out of psychotherapy.	Semi-structured interviews; Content Analysis (CA).	5 f, 2 m (7) No ethnicity reporting.	Former clients of psychotherapy services. Participants had dropped out of treatment.
Burton & Thériault. Canada, 2019	To explore how hindering events are experienced by clients and their influence on the therapeutic process and outcome from	Semi-structured interviews; Thematic Analysis (TA).	8 f, 1 m (9) No ethnicity reporting.	Clients, or former clients, of psychotherapy within private or public practice. Clients were either retained or dropped out of therapy.

	the client's perspective.			
Bury et al. United Kingdom, 2007	To develop an in-depth understanding of service users' perspectives and the way in which young people had made sense of their experience of Individual Psychoanalytic Psychotherapy (IPP).	Semi-structured interviews; IPA.	4 f, 2 m (6) No ethnicity reporting.	Clients who had received IPP within a community mental health clinic. Participants had engaged in at least 6 months of IPP weekly.
Hoskins et al. United Kingdom, 2019	To examine patients experiences of a new 10 session cognitive behavioural therapy (CBT) for bulimia nervosa.	Qualitative survey; TA.	17 f (17) No ethnicity reporting.	Clients who had experienced a course of CBT-T. Participants were either retained or dropped out of treatment.
Kehle-Forbes et al. United States, 2022	To examine the different experiences of veterans who completed or dropped out of	Semi-structured interviews; Deductive and Inductive Coding Analysis.	44 f, 82 m (126) 73 White; 34 Black/African	Clients who experienced PE or CPT within a veteran's clinic. Participants were either retained for, or dropped out of, treatment.

	trauma-focused therapies for CBT.		American; 16 Other.	
Knox et al. United States, 2011	To examine clients' experience of termination from individual outpatient psychotherapy.	Semi-structured interviews; CQR.	11 f, 1 m (12) 12 White.	Clients who had experienced psychoanalytic/psychodynamic therapy, CBT, interpersonal, or client-centred therapy in an outpatient setting. Participants initiated the termination process.
Råbu & Haavind. Norway, 2012	To examine when and how the theme of the ending is introduced, and explore the responses of the other party within the therapeutic dyad.	Session audio-recording, interviews; Narrative Analysis (NA).	1 f (1) No ethnicity reporting.	Client of a paid open-ended integrative form of psychotherapy. Therapist proposed therapy's termination.
Råbu et al. Norway, 2013	To explore how the decision to end treatment is negotiated within the psychotherapeutic relationship, and how the two parties retrospectively	Session recordings and semi-structured interviews; TA and NA.	10 f, 2 m (12) No ethnicity reporting.	Clients of paid open-ended integrative psychotherapy. Client and therapist-initiated terminations.

	experience the process of the ending.			
Wilson & Sperlinger. United Kingdom, 2004	To examine the experience of drop-out from the perspective of both patient and therapist for the same event.	Semi-structured interviews; IPA.	3 f, 3 m (6) No ethnicity reporting.	Long-term psychoanalytic psychotherapy within public funded NHS service. Clients initiated termination when their therapists disagreed.
Jung et al. Brazil, 2013	To better understand the factors associated with dropout from psychoanalytic psychotherapy (PP).	Semi-structured interviews; CA.	6 f (6) No ethnicity reporting.	Clients who experienced PP in an outpatient clinic. Participants dropped out of treatment.
Råbu & Haavind. Norway, 2018	To consider how clients view their own contribution and that of their therapist in the last phase of therapy when they are moving towards the end.	Interviews; TA.	24 f, 13 m (37) No ethnicity reporting.	Former psychotherapy clients, mixture of therapeutic disciplines and integrative approaches. Client-initiated termination, therapist-initiated termination, agreed termination, and disagreed termination.
Roe et al. Israel, 2006	To explore clients' feelings during	Open-ended questions; Inductive	66 f, 22 m (88)	Clients of a private psychodynamic psychotherapy practice.

	termination of psychodynamic oriented psychotherapy	Coding Analysis.	No ethnicity reporting.	Client-initiated termination, therapist-initiated termination, agreed termination, and disagreed termination.

Table 3

CASP Quality Appraisal Scores for Included Studies using Duggleby et al.'s (2010) three-point scale.

Author(s) (Year)	Research Design	Sampling	Data Collection	Reflexivity	Ethical Issues	Data Analysis	Findings	Value of Research	**Total Score**
Balmain et al. (2021)	2	2	2	2	2	3	3	3	**19**
Burton & Thẻriault. (2020)	2	2	2	3	1	3	2	3	**18**
Bury et al. (2007)	3	2	2	2	2	2	2	3	**18**
Hoskins et al. (2019)	3	2	2	1	2	2	3	3	**18**
Hundt et al. (2020)	3	3	3	2	2	2	3	3	**21**
Jung et al. (2013)	2	2	2	1	2	2	2	3	**16**
Kehle-Forbes et al. (2022)	2	2	3	1	2	2	2	3	**17**
Khazaie et al. (2016)	3	2	3	1	3	2	2	3	**19**
Knox et al. (2011)	2	2	2	2	2	3	2	2	**17**
Olivera et al. (2013)	2	3	3	1	3	2	3	3	**20**
Olivera et al. (2017)	3	3	3	2	3	3	3	3	**23**
Råbu et al. (2013)	3	1	3	1	2	2	2	3	**17**

Råbu & Haavind. (2012)	3	1	2	2	2	3	2	2	**17**
Råbu & Haavind. (2018)	2	2	3	1	1	2	2	2	**15**
Roe et al. (2006)	2	2	2	1	1	2	2	2	**14**
Wilson & Sperlinger. (2004)	3	1	3	1	2	2	2	3	**17**

Table 4

Example Data Extraction Table Completed with the Theme 'Termination Motives' from Client-therapist Agreement in the Termination Process and its Association with Therapeutic Relationship (Olivera et al, 2017)

Theme	Subtheme	Participant Quotes	Primary Author Interpretations
Termination Motives	Client reached goals/ Client felt better	'I decided to end therapy because I had been dating someone for the last 8 months, and I felt happy. I was starting a new part of my life, I felt happy again after quite some time, and I was feeling optimistic. (…) I said something like, "I think I don't want to come anymore." She said "Ok, if you ever need to, you know, you can call me.'	Termination motives were classified into nine categories, as a big variety of reasons drove participants and therapists to decide on terminating the treatment. Although there were no general or typical categories, those with a higher representation were positive motives such as the client fulfilling her/his goals, and/or feeling better.
	Therapy had run its course/ Client felt bored/ There was nothing new to talk about	'During the time I was in therapy I told the therapist the story of my life, and I asked her how can I look at this, what do I have to do. I was looking for a solution,	Rarely, there were participants that felt therapy had run its course, as in "was naturally finished or completed," meaning it

		for her to give me something that could help me manage things more easily. I didn't get that. (. . .) I finished each session and tried to remember what we had talked about, and I couldn't recall anything new, she'd only reaffirmed what I had said. We always talked about the same subject; I did not see any changes.'	as a positive feature. Other reasons for termination were a result of something going wrong in therapy or in the therapeutic relationship. For example, some participants felt bored or felt there was a lack of new themes to address in session.
	Therapy reached a limit/ Client was dissatisfied with therapy/therapist	'My therapist started going into areas of my life that I didn't want to analyze. I had gone to get help with issues at work, and she asked me a lot about my romantic relationship. It didn't end up having a negative effect because I stopped it, I left the therapy.'	Also in rare cases, they felt therapy had reached a limit and would not resolve issues that were still pending, as well as feeling dissatisfied with therapy or their therapist. Additionally, there were participants that decided to terminate the treatment because they needed to spend time without therapy or because they wanted a different

	therapy. Finally, there were reasons related to financial difficulties, such as not being able to pay because of the loss of a job.

Table 5

Example Translation Table for the Cluster of Datasets Pertaining to Agreement between Service User and Therapist about Ending Therapy

Descriptor (groups of similar concepts clustered together/ broad thematic headings)	**First Order Data (participant quotes)**	**Second Order Themes (themes developed by primary authors)**
Agreement between service user and therapist about ending therapy	'I was careful because I cared about what my therapist thought. I wanted to tell her about my desire to finish, but I didn't want to impose the timing of it. It was a joint decision, and I value it as very positive the fact that I proposed it and she supported the decision.' (Olivera et al., 2017)	Client initiated therapy's termination (Olivera et al., 2017)
	'I told my therapist I was not going to continue, and he didn't take it well. I brought it up one session, and then I told him I was leaving therapy. He said the timing wasn't right, because of the issues we were working on. But I felt stuck. I never went back after that time' (Olivera et al., 2017)	Client and therapist disagreed on termination (Olivera et al., 2017)
	'Joel: It would have been terrible if the therapist had said, 'Now I think it is time to end.' If I hadn't felt the same, I would	'It was important he agreed with me' – using consensus as a means of dispelling feelings of

	have felt like I was thrown out' (Rabu et al., 2013)	abandonment and a lack of competence Rabu et al., 2013)
	'Marian: Did we really plan that? I think you said it, not we. And I thought, okay, that remains to happen. Perhaps three more sessions, I thought' (Rabu & Haavind., 2012)	(Rabu & Haavind., 2012)
	'I explained why I was leaving the sessions and she understood me, told me to be happy, for me to try' (Jung et al., 2013)	Process termination (Jung et al., 2013)
	'I overcame the need to continue therapy only to avoid hurting my therapist' (Roe et al., 2006)	Termination as a practice of independence (Roe et al., 2006)
	'I was conflicted and brought up the topic in therapy. At first my therapist looked very stressed. He couldn't digest the idea I wanted to terminate. I didn't let that feeling bother me. I didn't get the response I was hoping for in terms of examining my desire to terminate in depth. But at least he didn't interpret it as resistance, which was a relief'. (Roe et al., 2006	Therapist's responses (Roe et al., 2006)

Table 6

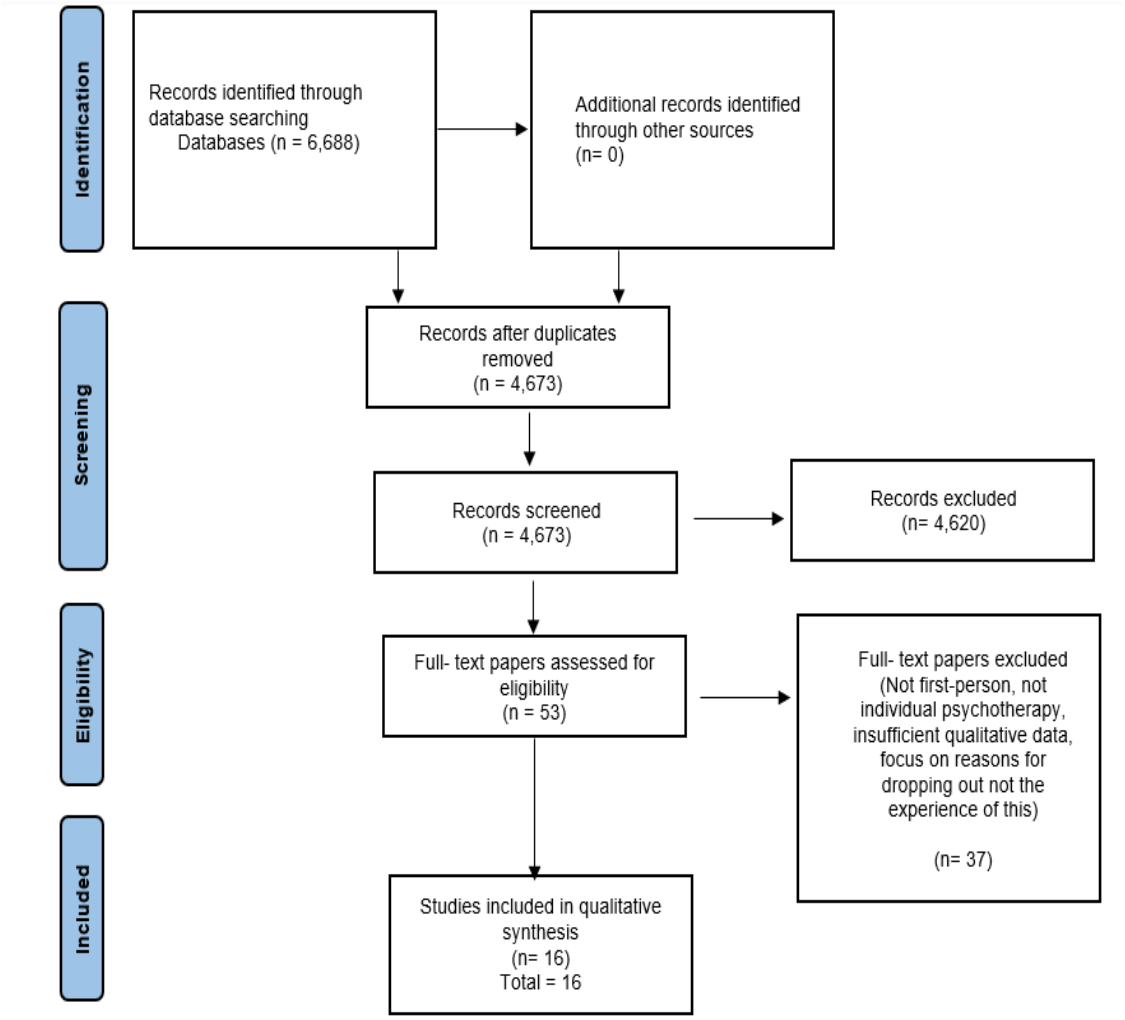
Table of Studies Contributing to Identified Themes

	Cohesion within the Ending Process				**Personal Agency Within the Ending**		
	Consensus to End Therapy	**Tools and Exchanges to Process the Ending**	**Unexplained Endings**	**Perceived Finality of Termination**	**Accepting Good Enough**	**Taking a Leap**	**Autonomy to End Unhelpful Therapy**
Olivera et al. (2017)	√	√	√	√	√		√
Hundt et al. (2020)					√		√
Olivera et al. (2013)	√				√		√
Balmain et al. (2021)		√		√			
Khazaie et al. (2016)							√
Burton & Thériault. (2019)							√
Bury et al. (2007)					√	√	
Hoskins et al. (2019)		√				√	
Kehle-Forbes et al. (2022)			√				

Knox et al. (2011)			√			√			√		√	
Råbu et al. (2013)	√		√			√		√				
Råbu & Haavind. (2012)	√		√			√						
Wilson & Sperlinger. (2004)				√					√		√	
Jung et al. (2013)	√			√								
Rabu & Haavind. (2018)		√		√		√		√		√		√
Roe et al. (2006)	√		√			√			√		√	

Figure 1

PRISMA Flow Diagram



Note. Adapted from "The PRISMA 2020 statement: an updated guideline for reporting systematic reviews" by M. J. Page, J. E. McKenzie, P. Bossuyt, I. Boutron, T. C. Hoffmann, C. D. Mulrow, et al., 2021, *BMJ*, 372(71). https://doi.org/10.1136/bmj.n71

Figure 2
Example of Reducing Themes into Relevant Categories Process

1) **Leaving the door open**

- Therapy did not have closure (Olivera et al., 2017)
- Therapist left “door open” for another treatment (Olivera et al., 2017)
- Client and therapist disagreed on termination (Olivera et al., 2017)
- Hassles and stressors differentially impact treatment engagement (Kehle-Forbes et al., 2022)
- ‘if I feel a strong need’ – utilizing the possibility of resuming therapy (Rabu et al., 2013)
- ‘that’s how you can use this summer’ – temporary breaks (Rabu et al., 2013)
- Interruption – reasons “I was unemployed, had this great excuse so to speak” (Jung et al., 2013)

2) **Agreement in ending**

- Client and therapist agreed on termination (Olivera et al., 2017)
- Termination mode – client-initiated therapy’s termination (Olivera et al., 2017)
- Termination mode – therapist-initiated therapy’s termination (Olivera et al., 2017)
- Termination processes - Patient and therapist expressed a range of emotions (Knox et al., 2011)
- ‘We have reached a new phase’ – The client cautiously leads the way and the therapist responds in a sensitive manner (Rabu et al., 2013)
- ‘it was important that he agreed with me’ – using consensus as a means of dispelling feelings of abandonment and a lack of competence’ (Rabu et al., 2013)

- ‘Perhaps she will come back later for another round’ (Rabu et al., 2013)
- Interruption – process termination “I explained why I was leaving the sessions and she understood” (Jung et al., 2013)
- “Termination as reflecting positive aspects of the therapeutic relationship” – therapist’s responses (Roe et al., 2006)

3) Ending as a relief from emotionally scary or painful experience

- Reasons for non-completion – emotional reasons (Hundt et al., 2020)
- Meaning attributed to increased distress and symptom worsening (Kehle-Forbes et al., 2022)
- Highly upset/devastated (Knox et al., 2011)
- Effect of termination on patients’ thoughts about future psychotherapy (Knox et al., 2011)
- Therapy as a threat and a loss of control, fear or dependence, loss or abandonment (Wilson et al., 2004)
- Avoidance of painful feelings (Wilson et al., 2004)
- Detachment from versus involvement with the help (Wilson et al., 2004)
- Change process – resistance (Jung et al., 2013)

4) Choosing to end as a means of creating space for more important things

- Reasons for non-completion – practical reasons (Hundt et al., 2020)
- Therapy termination – client proposed termination (Olivera et al., 2013)

- Hassles and stressors differentially impact treatment engagement (Kehle-Forbes et al., 2022)
- Anticipated impact of treatment on social and role functioning (Kehle-Forbes et al., 2022)

5) Endings with successful outcomes

- Termination motive – client reached goals/client felt better (Olivera et al., 2017)
- Therapy termination – cause for termination was reason for consultation resolution (Olivera et al., 2013)
- Mixed positive and negative feelings – “good about leaving, ready to handle problems on my own” might never find a therapist as good (Knox et al., 2011)
- Coming to terms with challenges in life and therapy made me ready to end - I experienced improvement and prepared for separation (Rabu & Haavind, 2018)
- “Termination as reflecting the positive gains experienced in therapy” (Roe et al., 2006)

6) Ending without a result seen as successful

- Therapy reached a limit/ client was dissatisfied with therapy/therapist (Olivera et al., 2017)
- Dissatisfaction with therapists’ rapport (Khazaie et al., 2016)
- Factors contributing to negative feelings - disappointment dissatisfaction and feelings of failure (Roe et al., 2006)

- Premature termination and need for further support – “there were additional things to work on” (Roe et al., 2006)

7) Ready for the next step

- Termination motive – therapy had run its course/ client felt bored/ there was nothing new to discuss (Olivera et al., 2017)
- Factors contributing to positive feelings – termination as a practice of independence (Roe et al., 2006)

8) Endings as an uncertain and conflicting time

- Endings – ambivalence (Bury et al., 2007)
- Endings – feelings of separation and loss (Bury et al., 2007)
- After therapy “Feel scared/anxious about ‘support’ once my last follow-up had happened” (Hoskins et al., 2019)
- ‘its hard to definitively let go’ – exploring autonomy and reducing loneliness (Rabu et al., 2013)
- ‘if we agree that we are approaching the end’ (Rabu et al., 2013)
- Factors contributing to negative feelings – loss of a meaningful relationship (Roe et al., 2006)

9) Endings as a process

- There was a closing period/session (Olivera et al., 2017)
- The process – ending therapy (Balmain et al., 2021)
- After therapy (Hoskins et al., 2019)
- Termination process - Talked about/planned termination (Knox et al., 2011)

- Discussed patients post-therapy support plans (Knox et al., 2011)
- Processing the termination (Roe et al., 2006)

10) Deciding to end as a result of being unsatisfied with the therapy

- Lack of buy in to treatment (Hundt et al., 2020)
- Felt disappointment/misunderstood at some point of therapy (Olivera et al., 2013)
- Dissatisfaction with therapist's rapport (Khazaie et al., 2016)
- Client response/decision to end therapy – client initiated premature termination "He never really provided me with practical ideas or reasons why" – (Burton et al., 2019)
- Therapists "in the trenches" with patients (Kehle-Forbes et al., 2022)
- Conflicting wishes for functional help versus intensive therapy (Wilson et al., 2004)

Appendices

Appendix A

Submission Guidelines for Psychology and Psychotherapy

Aims and Scope

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological and social processes that underlie the development and improvement of psychological problems and mental wellbeing, including:

• theoretical and research development in the understanding of cognitive and emotional factors in psychological problems;
• behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological distresses;
• psychological therapies, including digital therapies, with a focus on understanding the processes which affect outcomes where mental health is concerned.

The journal places particular emphasis on the importance of theoretical advancement and we request that authors frame their empirical analysis in a wider theoretical context and present the theoretical interpretations of empirical findings.

We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds both within the UK and internationally.

In addition to more traditional, empirical, clinical research we welcome the submission of

- systematic reviews following replicable protocols and established methods of synthesis
- qualitative and other research which applies rigorous methods
- high quality analogue studies where the findings have direct relevance to clinical models or practice.

Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in *Psychology and Psychotherapy: Theory, Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

Manuscript Categories and Requirements

- Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 8000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for Registered Reports.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

Preparing the Submission

Free Format Submission

Psychology and Psychotherapy: Theory, Research and Practice now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (if you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.

- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-anonymous peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

- An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at https://wiley.atyponrex.com/journal/PAPT and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use this template for your title page. The title page should contain:

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our Author Services site.

Abstract

Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading 'Practitioner Points'. They should briefly and clearly outline the relevance of your research to professional practice.

Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation "Main Document – LaTeX .tex File" on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as "Main Document - LaTeX PDF." All supporting files that are referred to in the LaTex Main Document should be uploaded as a "LaTeX Supplementary File."

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

- PDF of the finalized source manuscript files compiled without any errors.

- The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.
- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Abstract structured (intro/methods/results/conclusion);
- Up to seven keywords;
- Practitioner Points Authors will need to provide 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below);
- Statement of Contribution.

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association. The following points provide general advice on formatting and style.

- Language: Authors must avoid the use of sexist or any other discriminatory language.
- Abbreviations: In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- Units of measurement: Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- Effect size: In normal circumstances, effect size should be incorporated.
- Numbers: numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Appendix B

ENTREQ Statement

No	Item	Guide and description
1	Aim	State the research question the synthesis addresses.
2	Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology *(e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).*
3	Approach to searching	Indicate whether the search was pre-planned (*comprehensive search strategies to seek all available studies)* or iterative (*to seek all available concepts until they theoretical saturation is achieved)*.
4	Inclusion criteria	Specify the inclusion/exclusion criteria *(e.g. in terms of population, language, year limits, type of publication, study type).*
5	Data sources	Describe the information sources used (e.g. *electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists)* and when the searches conducted; provide the rationale for using the data sources.
6	Electronic Search strategy	Describe the literature search *(e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits)*.
7	Study screening methods	Describe the process of study screening and sifting *(e.g. title, abstract and full text review, number of independent reviewers who screened studies).*
8	Study characteristics	Present the characteristics of the included studies *(e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).*
9	Study selection results	Identify the number of studies screened and provide reasons for study exclusion *(e,g, for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications t the research question and/or contribution to theory development).*
10	Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings *(e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).*
11	Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings *(e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope* [25]*; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).*
12	Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.

13	Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.
14	Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? *(e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software).*
15	Software	State the computer software used, if any.
16	Number of reviewers	Identify who was involved in coding and analysis.
17	Coding	Describe the process for coding of data *(e.g. line by line coding to search for concepts).*
18	Study comparison	Describe how were comparisons made within and across studies *(e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).*
19	Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.
20	Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation.
21	Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. *new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).*

Retrieved from, Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC medical research methodology*, *12*, 1-8.

Appendix C

Translation Paragraphs of Primary Author Interpretations

Key –

Study	Number
Olivera et al. (2017)	1
Hundt et al. (2020)	2
Olivera et al. (2013)	3
Balmain et al. (2021)	4
Khazaie et al. (2016)	5
Burton et al. (2019)	6
Bury et al. (2007)	7
Hoskins et al. (2019)	8
Kehle-Forbes et al. (2022)	9
Knox et al. (2011)	10
Rabu et al. (2013)	11
Rabu & Haavind. (2012)	12
Wilson et al. (2004)	13
Jung et al. (2013)	14
Rabu & Haavind. (2018)	15
Roe et al. (2006)	16

Construct One: Cohesion within the Ending Process

Consensus to End Therapy

Paper 1 shows that individuals describe that most individuals feel it to be important that agreement is reached between themselves and their therapist about ending therapy regardless of which party introduces the ending. Emphasis is placed by service users on their therapist's responses to their wishes to end. Lack of agreement led to perceived rupture in the therapeutic dyad, and feelings of abandonment if the therapist attempted to initiate termination before the client wished this to happen. Paper 3 similarly found that service users focus on their interpretation of their therapist's reaction to the ending of therapy.

Paper 11 adds to the findings of Paper 1 and Paper 3, consensus is seen as important for individuals when therapy is ending and asserts that if the therapist proposes an ending before the participant is ready this is perceived as a negative experience of endings. Disagreement is interpreted by clients as their therapists feeling they have not made progress in therapy. Adds to therapist-initiated terminations before the client feels ready, service users express a sense of abandonment in these circumstances. Paper 12 also demonstrates the important of consensus, brings nuance to this showing that when there is disagreement clients may point this out however ultimately agreeing to end therapy. Paper 14 similarly demonstrates that service users focus on their therapist's response when they decide to bring up that they would like to end therapy. Paper 15, like Paper 11, asserts that service users interpret their therapists' agreement with their decision to end as a reflection of the progress they have made in therapy where agreement is perceived as an affirmation of their progress. Paper 16 appears to refute the importance of agreement within the therapeutic dyad, with some service users feeling that their ability to end therapy when their therapist disagreed indicated that they were able to put their needs before those of the therapist. However, asserts that focus is still given to the therapist's responses to service users wish to leave, and that disagreement is felt to be an expression of therapist's not feeling that service users have made therapeutic progress. Also adds to Paper 11, service users interpret that when they wish to end when the therapist does not they think the therapist themselves feels abandoned by them.

Tools and Exchanges to Process the Ending

Paper 1 expresses that services users who are uncertain about ending therapy are encouraged when their therapist discusses the goals and achievements they have completed together during the therapy. Paper 4 states that tools such as goodbye letters are encouraging for service users, increase future hope, and increase readiness to end. It grows on Paper 1 by explaining that these tools are also valued by service users as something which facilitates a positive ending of the therapeutic relationship. Paper 8 agrees with both Papers 1 and 4, service users found that reflecting on their therapeutic progress in ending sessions was encouraging and goodbye letters were a positive way of facilitating the end of the relationship. It additionally adds that service users felt that their therapist providing tips for them to use independently in the future provided increased hope. Paper

10 agrees with the above papers, recapping tools and techniques used in therapy during the ending sessions was felt to be helpful by service users alongside discussing thoughts and feelings related to ending therapy. Paper 11 introduces the idea of slowly reducing session frequency as a tool which is positively perceived by service users during the ending of therapy. Similarly to the above papers, service users connected the use of this tool to taking care of the ending of the therapeutic relationship also as service users felt this acclimatised them to not seeing their therapist. Adds to the above papers, shows that service users may initiate conversations about the positive therapeutic progress they have made with their therapists also as part of the ending process. Paper 16 service users find reassurance and increased future hope when the ending is a process which feels collaborative, and time is allowed for them to become used to the idea that therapy has ended.

Unexplained Endings

Paper 1 explains that some service users do not inform their therapist that they are planning to drop out of therapy, even if they know they plan to do this before attending for a final session with their therapist but chose to not share this information. It explores that these cases may happen when service users perceive that their therapist may disagree with their wish to end, or when service users think that therapists will feel that this is a personal attack. Paper 9 explains that service users may use excuses to end therapy such as personal life factors when they are unsure about, or dissatisfied, with the therapy or therapist. Paper 13 agrees with Paper 9 asserting that unexplained endings may happen when service users are dissatisfied with the therapy or therapist. It adds to the understanding of service users in relation to making these decisions asserting that people may deliberate whether to be honest about finding the therapy difficult but in the end chose to avoid this. Paper 14, similarly to Paper 9, finds that service users express to their therapists that real life circumstances are the reason for ending therapy when this is not a full disclosure of their reasoning. In this study, difficult feelings stirred up by the therapy are expressed as underlying the reason for ending therapy. Paper 15, similarly to Papers 9 and 14, document that life circumstances are used as excuses to end therapy when dissatisfaction with the therapy or therapist underlie the decision to end.

Perception Finality of Termination

Paper 1 service users feel that having the option to return to the therapy at a later date provided a sense of comfort. Paper 4 grows on this, when there was not an option to return to therapy service users wished they had the option for follow up support. Paper 10, like Paper 1, asserts that the option to return to therapy was perceived positively by service users and being able to utilise this if they felt they were coming across struggles felt reassuring. Paper 11 grows on Papers 1 and 3, service users feel a sense of safety and security when they can keep or resume contact with their therapist. The paper stipulates that the notion of continued contact may regulate feelings of rejection caused by the ending of therapy for service users. Paper 12 agrees with the above papers findings and stipulates that continued contact with therapists after therapy ceases is positively perceived by service users as a way of continuing the emotional bond fostered during the therapy. Paper 15, similarly to Paper 10 asserts that service users felt that the chance to return to therapy when things became difficult in life was a sense of comfort. Similarly to Paper 4, when continuing the therapy or relationship with the therapist was not an option, service users perceived this negatively and wanted to continue the relationship with their therapist. Paper 16 adds to the findings of Paper 4 and Paper 15, when continuing therapy was not an option service users perceived this negatively as they felt that therapy had not resolved all they wished it had done and felt these things could no longer be worked on.

Construct 2: Personal Agency within the Ending

Accepting Good Enough

Paper 1 states that service users chose to end therapy when they feel their goals have been met and have other things happening in their lives that they wish to have more time for. The study finds that when service users feel they want to put more time into other things in their lives, they feel it is then time to end. Paper 2 find that service users who drop out of therapy still report feeling that they achieved something important to them from participating in the therapy. Paper 7 grows on the findings from Paper 1 finding that service users decide to end therapy when circumstances change. Finding that when these things happen it is interpreted by clients as time to move on from therapy. Paper 15 grows on the above findings, stating that a sense of restlessness, feeling bored or tired of going to therapy, or feeling more ‘normal’ emotionally were the reasons service users decided to end the therapy.

Taking a Leap

Paper 7 asserts that service users experience the ending of therapy as a transitional period which evokes mixed emotions of excitement and fear towards the notion of life without therapy and their therapists. Paper 8 characterises participants felt a sense of anxiousness towards the ending of therapy. Paper 10 grows on these papers by exploring service user's sense of ambivalence towards their therapist, feeling that they were experiencing a large sense of loss towards the relationship alongside gratitude and thankfulness. It also agrees with Papers 7 and 8, expressing a sense of excitement alongside fear relating to navigating without therapy moving forwards. Paper 13 similarly comments on the difficult emotions provoked for service users by the loss of their therapist and feelings of dependence. It grows on the above findings by asserting that service users wanted to challenge their sense of dependency on their therapists through ending therapy but similarly discusses the conflicting feelings brought on by the newfound independence. Paper 16 similarly characterises service users experience of ambivalent feelings in relation to the end of therapy. Simultaneously expressing feelings of pride at finishing therapy and becoming increasingly autonomous whilst feeling nervous and apprehensive at the prospect of life without therapy. It also comments on the loss of the therapeutic relationship like Papers 10 and 13, with feelings of sorrow being experienced at the idea of the loss alongside positive feelings towards the relationship they had fostered during their time in therapy.

Autonomy to End Unhelpful Therapy

Paper One asserts that service users determined that their therapist would not help them address what they wished to and therefore decided in their best interests to leave as remaining in the therapy may be damaging to them. Paper 2 finds that those who dropped out of therapy became clear about the type of support which would be beneficial to them. Paper 3 agrees with the findings of Paper 1, finding that service users who experienced dissatisfaction with their therapist or therapy chose to end the therapy as they did not perceive change and felt that the therapeutic relationship was unhelpful. Paper 5 similarly to Papers 1 and 3 found that service users made the decision to leave when they felt that the therapy could be damaging towards them, it grows on the above papers as service users describe making these decisions in the interest of their mental health. Paper 6 similarly finds that service users executed their right to decide to end therapy when they were dissatisfied

with the therapy and felt they were not experiencing progress. Paper 10 similarly noted that ruptures which were perceived to not be amendable by service users led to a decision to end therapy as remaining within it would be damaging. Paper 13 demonstrates that service users left therapy when they were dissatisfied with the therapy or therapist and felt that it would not be beneficial to continue. Paper 15 differs from the above papers as service users did not choose to leave therapy, they describe similar experiences of finding the therapy to be unhelpful however express a sense of disappointment. Rumination on their decision to remain in the therapy despite finding it to be unhelpful. Paper 16 is similar to Paper 15 in which service users elected to remain in an unhelpful therapy and expressed negative feelings towards it due to their dissatisfaction.

Section Two: Empirical Paper

Therapists' Beliefs and the Real-World Practice of CBT for Depression - A Reflexive Thematic Analysis

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Abstract: 180

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Abstract

Objectives: This study aimed to explore how psychological therapists conceptualise therapeutic change in Cognitive Behavioural Therapy (CBT) for depression, and how these beliefs shape their clinical practice. **Method:** Twelve UK-based psychological therapists with experience delivering CBT for moderate to severe depression participated in semi-structured interviews. Reflexive Thematic Analysis (RTA) was used to identify patterns of meaning across the dataset, with a focus on therapists' meaning making and conceptual understandings. Reflexivity was embedded throughout the process to enhance transparency. **Results:** Three over-arching themes were developed: 1) Therapists' active attempts to facilitate perceptions of themselves as empathetic, honest, and hopeful for clients; 2) Fostering clients' agency and accountability to change within and beyond the therapy space; 3) Using CBT tools to serve the higher-order goals of revising self-perceptions and aligning with personal values. Tensions between protocol fidelity and therapists' beliefs about their therapeutic approaches were evident. The analysis yielded insight into how therapists navigated these conflicts**. Conclusions:** This study sheds light on how therapists balance fidelity to CBT protocols for depression with their beliefs about what facilitates meaningful change for clients.

Introduction

There are approximately 280 million people living with depression, exemplifying its status as one of the most prevalent mental health disorders globally (World Health Organisation [WHO], 2023). Symptoms include psychological, cognitive, and physical difficulties, such as feelings of worthlessness, trouble concentrating or making decisions, and persistent fatigue (American Psychiatric Association [APA], 2013). The pervasive nature of these symptoms can impact daily functioning, contributing to significant decline in mental and physical health (Hohls et al., 2021). Depression is also a major risk factor for suicidality, posing a serious public health concern (Baldessarini et al., 2019). Given its widespread and debilitating effects, depression ranks among the leading causes of global disability (Friedrich, 2017) and contributes substantially to societal economic problems (McDaid & Park, 2022). Considering the profound personal and economic impact of depression, access to targeted and effective treatment is paramount.

Cognitive Behavioural Therapy (CBT) is widely regarded as the gold standard psychological intervention for depression (Kambeitz-Llankovic et al., 2022). It is recommended by the National Institute for Healthcare Excellence (NICE, 2022) as a first-line treatment. The structured and time-limited format of CBT makes it well-suited for evaluation in controlled trials, and its effectiveness is supported by a substantial body of empirical evidence (Gaudiano, 2008). Meta-analyses indicate CBT produces clinically significant reduction of depressive symptoms compared to control conditions (Cuijpers et al., 2016), with effect sizes comparable with use of antidepressant medications (Werson et al., 2022). These effects have been demonstrated across a broad age range, including children, adolescents, adults, and older adults (Oud et al., 2019; Werson et al., 2022).

Despite its robust evidence base, CBT is frequently adapted in real-world clinical settings, with therapists often deviating from protocols (Bruijniks et al., 2018). Research suggests these deviations are driven by a range of clinical considerations, including clients' cultural beliefs (Hinton & Patel, 2017), perceived disengagement or rejection of CBT approaches (Snippe et al., 2019), organisational constraints, comorbid difficulties, and suicidality (Bruijniks et al., 2018). Whilst these adaptations may represent efforts to provide individualised care within complex care settings, they raise concerns about adherence to empirically tested models (Kendall & Frank, 2018).

A central component for understanding CBT therapists' clinical reasonings is their implicit working models (Schön, 1983; Bennett-Levy, 2006). Implicit working models are internal, often unconscious, frameworks developed through personal beliefs, clinical experiences, professional training, and reflection. These models inform therapists' clinical perceptions and decision making (Nakash & Alegría, 2013). For example, CBT therapists' working models may include alignments with schools of thought concerning psychotherapy change agents. Some researchers consider CBT to be a superior treatment for depression (Tolin, 2010), citing specific techniques such as cognitive restructuring (Hollon et al., 2006) and behavioural activation (Jung & Han, 2024) as key mechanisms of its effectiveness. In contrast, others argue that psychotherapies achieve relatively equal outcomes (Wampold et al., 1997), attributing treatment success to common factors shared across therapeutic approaches. These include therapist qualities (Wampold & Imel, 2015), the therapeutic relationship (Wampold & Imel, 2015; Mikulincer et al., 2013) and the development of client insight (Jennissen et al., 2018). Such internal frameworks, whether favouring specific techniques or common factors, shape how CBT therapists operate in clinical practice, influencing the emphasis they place on therapeutic tools (Kuyken et al., 2011).

Deepening understanding of CBT therapists' belief and confidence in their therapeutic approach is particularly important. A growing body of research indicates that therapists' belief in, and confidence about, their chosen approach can influence client outcomes. Therapists holding strong beliefs in their approach's efficacy are significantly less likely to experience premature termination of therapy by clients (Bartle-Haring et al., 2022); a factor linked to lower client satisfaction and poorer treatment outcomes (Swift & Greenberg, 2012). Conversely, therapists who experience professional self-doubt have been associated with reduced symptom improvement for clients (Odyniec et al., 2017). Despite identification of these associations, limited research explores how therapists conceptualise the therapeutic process they aim to facilitate. Tzur Bitan (2022) found that therapists identified the therapeutic relationship, therapist characteristics, modality-specific techniques, professional training, and client motivation as key therapeutic factors. However, the study did not qualitatively explore how these beliefs influenced clinical practice, it also lacked consideration of potential differences in beliefs resulting from allegiance to different therapy models. Similarly, Donald et al. (2018) qualitatively explored therapists' perceptions of mechanisms of change in therapy with young people, emphasising the importance of re-engaging in age-appropriate activities, experiential learning, and a responsive therapeutic relationship. While providing valuable insights, their findings are limited by a small sample size.

There is a growing trend in psychotherapy research towards practice-based evidence approaches (Holmqvist et al., 2013). Traditional evidence-based practice approaches focus heavily on randomised controlled trials (RCTs) and manualised interventions, while practice-based evidence considers the application of psychotherapies within real-world clinical settings. This movement responds to critiques of RCTs regarding

their external validity to clinical practice settings (Rief et al., 2022). The exclusion criteria of trials investigating CBT for depression frequently includes comorbid presentations such as high risk of suicide, or substance use difficulties (Kopf-Beck et al., 2020). However, depression frequently coincides with these factors (Swendsen & Merikangas, 2000; Panagioti et al., 2012). Comorbid presentations are a common reality in psychotherapy services, therapists frequently work with clients whose complexities are not reflected in the participant profiles of clinical trials informing protocolised interventions (Catalao et al., 2024). Despite this, research suggests that psychotherapies delivered in real-world clinical settings produce a large effect size (d = 1.29; Cahill et al., 2010). Whilst more caution may be required when interpreting this data, as it is less controlled than clinical trials, it suggests the way therapists apply their therapeutic approaches in real-world settings remains effective.

Understanding therapists' beliefs regarding CBT for depression remains under explored, yet it is integral for illuminating how therapeutic approaches are implemented in real-world clinical practice. Clarifying therapists' beliefs regarding how they conceptualise their approach produces change, how they modify their clinical practice to fit these beliefs, and what they perceive to be indicators of successful therapy is fundamental to address the gaps in the evidence base. Specifically, this research aims to investigate:

1. What do psychological therapists who use CBT for depression believe about how the therapy works?
2. What outcomes mean that a therapy has worked?
3. What processes lead to these outcomes occurring?
4. How do these beliefs impact on therapists' clinical practice?

Methodology

Design

An inductive qualitative design was selected to facilitate the exploratory nature of the research questions. It sought to yield rich data concerning therapist's interpretations of how CBT creates change for individuals experiencing depression. The inductive approach allowed for participant responses to drive the analysis procedure and themes to emerge directly from the data without imposing pre-existing theoretical frameworks (Morse, 2015). The epistemological approach of the study was of a critical realism perspective (Bhaskar, 2008); asserting that there are objective realities of CBT, depression, mechanisms of action, and outcomes. These realities will exist independently of therapists' perspectives, which are mediated by social, cultural, and psychological variables. A 'Big Q' Reflexive Thematic Analysis (RTA; Braun & Clarke, 2006; 2022) was conducted, in which generating understanding of therapists' beliefs were prioritised over descriptive or summarised findings (Braun & Clarke, 2013; Howitt, 2010). This approach was determined to be well suited to the research questions. It allows patterns of meaning to be identified in therapists' depictions of CBT for depression, whilst acknowledging the researcher is an active participant in meaning-making through active engagement with the data (Braun & Clarke, 2019). RTA is a flexible approach, however, stating the theoretical underpinnings of the research is vital as the interpretative lens shapes all stages of research and thus is inseparable from the outcome of the analysis. Transparency regarding theoretical stance is therefore paramount for credibility (Braun & Clarke, 2019).

The study was reviewed by Lancaster University's Faculty of Health and Medicine Ethics Committee (FHM REC Reference: FHM-2024-4854-RECR-3) and approval to begin the study was provided on 20/12/2024.

Procedure

A multifaceted approach to recruitment was taken. A poster (Appendix A) detailing the research aims and inclusion criteria for participation was advertised on social media pages, such as Facebook groups designed to be used by CBT therapists. Personal networks were utilised, the research team contacted peers who were likely to know individuals meeting inclusion criteria. The study poster was shared with them. After receiving expressions of interest from advertisement, the participant information sheet (Appendix B) and consent form (Appendix C) were emailed to participants to read and sign prior to the interview. Interviews were conducted via Microsoft Teams. This increased accessibility of the study, allowing individuals based considerable distances away to participate and eliminating the resources and time required for travel (Archibald et al., 2019).

Congruent with the inductive design approach, a semi-structured interview style with a flexible topic guide was implemented (Appendix D). This aimed to ensure that, whilst interviews did not drift from the research aims, therapists' responses and insights shaped the discussion. This method allowed for therapists' views to remain paramount, drive the data generation and thereby inform analysis (Creswell, 2016; Seidman, 2006). The interviews ranged between 34 – 62 minutes, lasting 51 minutes on average. At the end of interviews, a short debrief took place to ascertain participants' wellbeing and notifying them of their right to withdraw (Appendix E).

Participants

Those eligible for participation were English-speaking, UK-based individuals whose job role included the delivery of psychological therapy. Participants had experience of using longitudinal CBT formulations collaboratively with individuals for a primary presentation of moderate-severe depression. Collaborative longitudinal formulation was stipulated as these formulations demand a deeper understanding of clients' histories and therapeutic processes, compared to less in-depth approaches such as maintenance formulations. Participants were required to have one years' minimum experience in their job role to ensure sufficient experience of utilising CBT knowledge within practice, and exposure to real-world clinical populations. Individuals were excluded from participation if they were training for a psychological therapist role, or if they had not used CBT for depression for two, or more, years. This aimed to ensure recency and accuracy of recollections.

In RTA, depth of understanding offered by participants' accounts in relation to the phenomena of interest is valued over frequency of content (Braun & Clarke, 2022). Information power (Malterud et al., 2016) influenced consideration of sample size. This framework suggests that highly specific participant samples provide more focused and meaningful data. The inclusion criteria stipulated that therapists must have sufficient clinical experience, a minimum of one year. Based on this, a target of ten participants was initially set. The quality and depth of generated data was monitored throughout recruitment to assess whether additional participants were necessary. This process resulted in a final sample of twelve participants. Table 1 provides an overview of participant information.

Analysis

The six iterative phases of RTA were followed, as described by Braun & Clarke (2022). Firstly, the primary author familiarised themselves with the dataset through interview transcription and repeated active reading. Secondly, initial codes were generated to label content of interest in relation to the research questions (Appendix F). A semantic approach was taken, prioritising the meanings conveyed by participants. Thirdly, codes were examined for connections, broader patterns, and meanings in relation to the research questions. Those sharing similar conceptual meanings were grouped into potential themes, and a concept map was used to explore their relationships (Figure 1). Fourthly, candidate themes were reviewed in supervision with the second author to assess for clarity and coherence in relation to the datasets they encapsulated. Themes were iteratively refined until each reflected a coherent and meaningful pattern across the dataset. Fifthly, themes were finalised and their scope and content clearly defined. Theme names, derived from participant quotes, were chosen to centre participants' perspectives. Sixthly, themes were woven into an analytic narrative, with illustrative data extracts utilised to construct a coherent understanding of participants' beliefs.

Reflexivity

Braun & Clarke's (2022; Appendix G) 15-point thematic analysis checklist was adhered to throughout the research process to maintain rigor and transparency. Initial generated codes, and a concept map of collapsed codes, are provided to illustrate the analytic process and the researchers' influence on theme development. Data extracts are embedded into the analysis to centralise therapists' perspectives and enhance transparency.

The primary researcher is a Trainee Clinical Psychologist who has been introduced to several therapeutic modalities during training. They are drawn to approaches postulating the therapeutic relationship as a tool for change, such as Schema Mode Therapy (SMT; Young et al., 2003). This may have influenced their engagement with the data, particularly in identifying meaning related to the therapeutic relationship. To maintain reflexivity, the researcher kept a reflexive journal to document assumptions and emotional responses arising during the process.

A third-party colleague was provided with emergent themes and data extracts, then invited to challenge potential researcher biases. The colleague suggested an alternative grouping method based on the type of CBT intervention used. However, after discussion, the first authors thematic structure was found to capture higher-order meanings not reflected in the proposed grouping. The colleague agreed that the emerging themes remained the most robust presentation of the data. The supervision team also reviewed emergent themes, reflecting on their own and the first author's potential biases. The team questioned the first authors interpretation and reviewed supporting data. The team identified theory driven language emerging in theme construction. This was reviewed collaboratively, and theme descriptions were revised to centre participants' meaning.

Thematic Analysis

The analysis process yielded three overarching themes, each with associated subthemes, as demonstrated by Figure Two.

Theme One: "There's some real power in that relationship that you've got with them"

A strong theme emerging from the data was participants' perspectives of the therapeutic relationships they foster with individuals experiencing depression. Participants were concerned with, and actively attempting to manage, perceptions their clients hold of them. It comprises of three elements: being interpreted as a person who can meet the client's emotional needs, being felt to hold trustworthy personal attributes, and being viewed as hopeful that the therapy can result in positive outcomes.

Subtheme One: "You've got a therapist who's saying 'no actually you're cool, you're good'"

Participants perceived an aim of their therapeutic approach to be correcting negative relational experiences, felt to be common for clients who experience depression. They described believing that these clients are *"marginalised by society" (Alyssa)*, have prior experiences of being *"fobbed off by mental health services" (Carl)*, and experience early relational experiences resulting in *"unmet emotional needs" (Sam)*. One participant explicitly expressed belief that, in terms of the therapeutic relationship, you should *"build that before you start" (Laura)* model specific tools. Most participants believed they should provide *"a different [relational] experience" (Ruth)* to ones of rejection and dismissal they hypothesised their clients had experienced.

"That helps a person feel like I'm not broken […] Like someone cares enough to take time to understand me, and they want to help me and they are going to help me with this and I can be helped" (Alyssa)

Participants believed that experiencing these relational dynamics allows clients "*… to maybe realise what it's like to have their needs met*" *(Nicola).* Verbal and non-verbal tools were described which were felt to facilitate this process.

"It's partly with non-verbals, so like my manner with people […] I try to kind of show people quite a lot of warmth and, you know, kind of smile at people and ask them how their journey was and how they are and make eye contact with them and that type of stuff, offer them a drink" (Alyssa)

Many participants hypothesised this facilitates change as clients can internalise the relationship and *"take [the relationship] into the wider world" (Ruth)*. Learning to apply the relationship to themselves and others.

"It's modelling positive regard, […] non judgementality, […] acceptance and compassion […]. It helps their self-esteem. It helps them to see themselves as a good person. It helps to see them, to give them hope." (Alyssa)

Four of the participants reported client feedback describing internalisation of their voice supported their belief in this process.

"People go away and be like, 'Oh, I heard your voice in the back of my head asking me, What does that mean? or Why might that be?'" (Paige)

Paul felt that his belief in the significance of facilitating this relational experience was at odds with his CBT training:

"…almost goes against some of the things you get taught on CBT training, you get told to teach the client to be their own therapist […] when it's that brutal and grim they kind of need you cheerleading and holding the emotional weight for them."

Subtheme Two: "If it doesn't feel authentic it's not going to hit the mark"

An internal goal of the therapeutic relationship was described as being perceived by clients as authentic and honest. These perceptions were felt to be important as clients

experiencing depression are *"honest people and transparency is a big thing where nobody likes bullshit" (Laura).* Participants evoked an image of a felt sense for clients about their personal qualities, believing that authenticity was foundational for generating trust.

"People know when you're being authentic and that's what usually forges trust" (Ruth)

Ruth explicitly expressed believing that facilitating this perception for clients was more influential than their assessment of her therapeutic expertise:

"If you can trust the person you're working with, even if they're not the most highly skilled practitioner - if you've got a faith in what they're introducing you to and what they're potentially asking you to do. Then you're more likely to do it, if you feel that you trust someone"

The image of authenticity and honesty was stipulated as particularly significant within CBT, as it legitimises the delivery of re-appraising cognitions.

"You're trying to talk about, like fact or feeling, aren't you? In terms of negative thoughts and stuff, especially with depression. To be able to have that transparency and know that I'm not biassed […] we can evaluate things in a balanced way without me trying to paint everything as positive […] where we can look at stuff and we can call a spade a spade, but we can also see if there are any positives or different situations" (Laura)

Subtheme Three: "I believe it works […] they say, 'oh, I feel like things can get better'"

Contradicting the feelings of hopelessness and helplessness experienced by depressed clients was described by participants as a function of their therapeutic relationships. Many described these feelings as pervasive in the therapy space, and Sam conveyed that depressed clients can be depicted in services as *"like a Dementor, that sucks*

the joy out of you". Participants reported their relational work requires awareness that feelings of hopelessness may be internalised by them and subsequently reinforced for clients.

"There's a sense of hopelessness and helplessness, and I think we could easily buy into that" (Ruth)

"Coming in maybe feeling less hopeless" (Sam) was depicted to be an internal goal of participants' therapeutic approach. Some believed conveying their personal conviction in CBT was paramount to facilitating hope. Alyssa felt that expressing belief allowed her to be *"more enthusiastic and evangelical when […] delivering that with clients and that's going to rub off on them".*

Participants reported that their faith in the model's ability to create change can transfer to clients and increase therapeutic engagement.

"…because I believe it works, I come in with that optimism and hope, so I think I'm very good at engaging even with people that are feeling very, very stuck." (Melissa)

However, many participants expressed their belief in CBT's ability to create change is impacted by several factors, such as *"if a client has […] comorbidity with other difficulties" (Alyssa)* or low perceived *"psychological mindedness" (Nicola)*. They described clinical experiences of *"working with autistic clients" (Tia)* and service *"pressure to keep to protocol […] sometimes felt very impersonal" (Nicola)*. Belief was described as fluctuating depending on *"seeing it being effective for people" (Sam).*

Despite this, some felt that communicating a confidence in CBT remains important even when their internal belief differs from this.

“They want to know that you're feeling confident that ... you've got the ability to do it. Even if you're like, Oh my God, I have no idea what to do in this situation. I've never dealt with anyone like before. And you're like, ‘Yeah, I've seen this loads. We'll be fine.’” (Sam)

Theme Two: “They’re buying what you’re selling”

This theme details participants perspectives that CBT is a therapy which clients are likely to need to continue independently after sessions, to maintain and continue therapeutic gain. It explores perspectives of a requirement to facilitate perceptions for clients that the therapy is relevant to their experiences, and counter feelings of hopelessness with ones of agency to create change. This theme consisted of three elements: working towards a penny drop moment when clients relate the CBT model to themselves, clients realising that they are the agents of change, and the work of making changes.

Subtheme One: “That’s kind of when the penny drops and they’re like ‘Oh yeah that’s definitely me’”

Participants described promoting a viewpoint for clients that CBT offers an alternative perspective of their difficulties, which is salient to their personal experience, as an internal goal of their approach. Most described that *“you’re giving people a big ask when you ask them to come to therapy” (Melissa)*. CBT was characterised as cognitively demanding in nature, it was believed that this can sometimes be misaligned with the needs of clients experiencing depression, as its symptoms *“can really impact on people’s motivation”* (Ruth).

Many felt a large aspect of their role was to facilitate a perception that the CBT belief system is relevant to clients’ experiences.

"Therapy a lot of the time is selling […] you're pitching things to clients" (Sam)

They believed creating this perspective for clients produces change as it serves to *"take away some of that shame […] normalise what they are going through […] confirm their symptoms" (Tia)*. Participants described the value of psychoeducation aligning with clients lived experience, but depicting depression, as *"a really common thing that people go through" (Laura)*, rather than an experience of shame and perceived difference from others.

"*Make them feel like they're not alone in in what they're going through and, you know other people must go through this too if it's conceptualised in that way" (Tia)*

Participants believed that when clients could reframe depressive symptoms as products of modifiable mechanisms, rather than immutable character differences, it led to a hopefulness for change. Clients experienced increased motivation as a result.

"I think if we can see things ourselves […] it's much more of a carrot for people when they're not feeling motivated." (Ruth)

Maintenance formulations were depicted as supporting to elicit this viewpoint. Ruth described this process as, *"mapping out and helping people to draw those connections on their own experiences"*. Feedback from clients was described by Laura as demonstrating that a perspective shift had been facilitated, and the CBT belief system has been endorsed.

"It can alleviate some of them secondary emotions […] 'I'm pissed off because I've done this, and I should be able to do this' but actually they can see why they might have reacted in a certain way".

Subtheme Two: "You probably could get yourself out of this mess a bit if you wanted to"

Promoting clients to believe that they have agency to make changes, which will improve depressive symptoms, was described by participants as a therapeutic target. They frequently described depression as including belief systems that *"there's only one right way to do things […] that does create a lot of turmoil" (Nicola)*. Some participants expressed consciousness regarding balancing their aim for clients to *"think about themselves in a more helpful way" (Carl)* whilst recognising they often feel *"a real lack of confidence because of a lot of experiences of being told what to do […] that can really erode people's confidence" (Ruth)*. Psychoeducation materials were described as tools which facilitated the idea that *"there are things that we can do differently here" (Sam).* The intended outcome of psychoeducation was described as to *"instil a little bit of hope that people could feel different" (Ruth)*.

Some participants described their goal of promoting the idea of alternative actions as a sensitive one, aiming to avoid clients feeling *"dictated to and told what to do" (Ruth).* Socratic questioning techniques were defined as supporting this approach, encouraging clients to generate ideas for themselves.

"through guided discovery and Socratic questioning, trying to help them come up with as much as they can" (Carl)

Building on the above quote, participants stipulated this approach to be integral when working with depression as not to collude with *"that internal dynamic of berating themselves, attacking themselves" (Carl)*. An internal goal of supporting clients to *"realise their own agency" (Nicola)* was described. One participant believed that Socratic questioning was also of significance as "*if they've made a discovery themselves, then they're*

much more likely to then utilise that learning because it uses a different part of the brain" (Alyssa). Participants felt their goal of facilitating client-generated ideas for change could sometimes contradict with their urges to share skills they felt would benefit clients.

"…because you're thinking, what are the gaps, what are the blocks that are going to help them make progress?" (Sam)

Mariam described conflict between believing that she had a therapeutic responsibility to *"teach [clients] these different things"* but *"if there's any kind of whiff of you trying to push them in a certain direction […] that's the path to someone disengaging"*. Traversing the careful balance of introducing skills, whilst allowing clients to self-identify areas they want to improve, was described by the majority of therapists as characteristic of collaborative work.

"you could say 'Well, which of the techniques that we've looked at could you apply to this problem'. […] you're trying to do it in a sort of collaborative sense, you've got in your mind that I'm trying to teach them these different things. I've got to bring them in at some point so it's trying to scaffold them on." (Sam)

Subtheme Three: "You're only with me an hour a week […] so the work is your work"

Facilitating a sense of accountability for clients about their therapeutic progress was conveyed as important by participants. Accountability was believed to underpin CBT's intention, to upskill clients with techniques they can apply in the future.

"it's a bit like you've got that Biblical proverb […] feed a man for a day and you feed him for a day, teach a man how to fish, and you feed him for a lifetime" (Paul)

All participants described CBT as *"a doing therapy" (Mariam).* With many expressing that, whilst change may occur during the therapy, *"you have to continue gathering evidence […] even post-therapy" (Tia).*

Explicit expression to clients regarding their accountability within the therapeutic process was described by many participants as a part of their approach.

"I often use the analogy of like belt and braces kind of approach […] if you don't do anything different outside, when you're out in your real life it's going to make absolutely no difference" (Alyssa)

Expressing this to clients was described to be therapeutic, as it opposes their beliefs that they are helpless and cannot create change for themselves.

"…helping them to take a bit of accountability themselves to get better […] can be so affirming" (Sam).

Overtly explaining CBT's requirements of clients to be active agents in therapy was described as an attempt to keep them from believing that they are dependent on their therapists to create change. Ruth expressed her therapeutic approach needed to demonstrate to clients that they held their own knowledge, which would inform positive change, otherwise they may feel they require therapist expertise to remain well.

"To equip people to know that they're resilient and the answers are within […] my skill is to apply my understanding to help them make sense of that […] because that's what's going to need to be taken forward, otherwise we'll need to keep coming back to the expert".

Some participants believed they represented a figure of accountability for their clients, which they hoped would be internalised during the therapy process.

"People have reported that they found it quite helpful to have someone that they're kind of accountable to […] obviously at some point I want them to try and do it independently" (Sam)

Paul described taking a *"hands on"* approach to reinforce accountability to his clients. Challenging them in sessions when they had not taken actions they had discussed with him during therapy.

"Okay you've been saying all the time about sending your mate a text […] What's stopping us right now? Pull your phone out, go and send your mate a text"

Many participants felt setting clients tasks to complete outside of sessions developed their accountability, *"because you put it down on a piece of paper and you know you're coming back to therapy next week" (Tia)*.

Scaffolding was postulated as a technique applied to develop clients' abilities to problem solve difficulties and come up with ways they may overcome them. Participants described working alongside clients whom they perceived to be most significantly compromised in their mood to plan change.

"If someone's quite depressed, quite overwhelmed at the concept of the world and making these changes and struggling to commit to something […] for some clients you have to get a read on them and you say 'look we need to be quite thorough with the plan so that you stick to the plan here'" (Paul)

Theme 3: "Giving them that bit of insight […] 'What do I need now to help me navigate it a little bit better'"

This theme depicts participants' beliefs that revising clients' critical self-perceptions is a mechanism of their therapeutic approaches. It was believed that reframing clients' present difficulties as understandable within the context of past negative experiences facilitated new, healthier self-perceptions. These new self-perceptions were described as leverage to support clients to engage with activities reflecting their personal values. It contains two components: facilitating new perceptions for clients about their histories and current difficulties, alongside promoting activities reflective of personal values.

Subtheme One: "…enabling themselves to be a bit kinder to themselves as to why they're where they're at"

Exploring clients' difficult life events and reflecting on how they may have shaped a sense of self was described by participants as key elements of their therapeutic approaches. Through this process, they supported clients in constructing alternative narratives that challenged deeply held beliefs of personal deficiency. Participants described depression to coincide with self-beliefs of innate difference from other people, such as *"'I'm not normal and I'm broken'" (Kate)*. All participants postulated these beliefs to result from internalisation of lived experiences of trauma and adverse experiences, leading to rigid beliefs about self and others. All participants expressed an integral part of their work as facilitating revised self-perceptions. They believed that *"drawing links" (Melissa)* between personal histories and current difficulties with depressive symptoms aimed to encourage clients to be "*a bit more curious rather than critical about their processes" (Laura)*.

“There’s no wonder that you're feeling the way you're feeling because look at all this stuff that's happened […] well, there's no wonder that you're doing these things to try and manage that” (Mariam)

Many participants hypothesised that clients experience distressing thoughts as *“a mess in [their] head” (Mariam)* before they are understood in the context of their past life experiences. Carl described using a metaphor, aiming to support clients to externalise the origin of their thoughts, contextualizing them as deriving from difficult experiences rather than internal defectiveness.

“If you imagine a plane coming in from really high above the clouds and dropping a bomb... if you didn’t know the plane was there you might just come to the assumption that you’re surrounded by fire and chaos [...] a negative automatic thought, for example, can be a bit like a plane dropping a bomb and then disappearing without you realising what’s going on.”.

All participants described using longitudinal formulations as a tool to *“take away some of that self-blame” (Paige)* and encourage clients to *“offer themselves a little bit of compassion” (Sam).*

“If you can actually identify these experiences that again helps that person to see, ‘right okay it’s not a problem with me or my personality, it’s that life has kicked me quite a lot of times’” (Alyssa)

Many participants felt formulations can have negative consequences for clients, as facilitating a perception that past negative experiences are affecting them presently can be *“really emotional, quite overwhelming” (Paul)*. Melissa reflected that encouraging clients to

believe that difficult past experiences as responsible for them feeling *"stuck for all that time"* can be *"devastating"* and *"painful"*. Paige expressed her belief that providing clients with alternative perspectives on their difficulties may be providing them with a narrow framework of which to perceive the world.

"Giving someone insight into something that's a hypothesis, and sometimes that can be taken as truth and facts […] There is a tendency in therapy sometimes for people to not put things across as tentatively as they should […] once a link is made, its very very difficult to break"

Paige further expressed that when clients believed the connections made between the past and present, this can have consequences, such as clients viewing once cherished relationships as negative.

"We linked a lot of things that happened in her past growing up and her relationship with her parents, that was basically related to the way she was thinking […] it really, really broke down a main support network that she had"

Subtheme Two: "Build upon things that are more and more meaningful […], reclaim their life back"

Reconnecting clients with meaningful activities, related to their personal values and revised self-perceptions, was devised as a goal by many participants. This was defined by Mariam as "r*econnecting people with things they've lost contact with"* and supporting clients to find *"what's important to them"*. Participants conceptualised depression as often coinciding with *"loss of motivation"* and *"loss of interest in previously enjoyed activities" (Alyssa).* This disconnection was hypothesised to often derive from feelings of pressure or

expectations from others, accumulating in clients feeling *"they were never allowed to pursue" (Nicola)* their interests. It was also felt to result from situational or life circumstances, resulting in loss of activities strongly connected to clients' sense of self.

"He'd retired a number of years before […] It was really him that came to the conclusion, 'I can see what it is I've lost my identity'" (Ruth)

Most participants described believing in *"a strong connection between what we do and how we view ourselves and who we are" (Mariam).* Alyssa felt that negative life events had *"changed the contingencies of reward and punishment for that person's life"* and expressed an internal goal of *"recalibrating what that person finds valuable".* When clients expressed feeling obligated to continue unenjoyable activities, as they were expected of them by others, participants depicted that not colluding with these perceptions was paramount. They described their approach should openly encourage clients to explore other options, and what it may be like should they chose them.

"if this it really isn't for you, what would be the options? What would you like to do? Whether it's thinking about values, dreams, you know, passions, interests and all that or thinking about, well, what if you stayed and what could you do about that?" (Nicola)

Participants described internal goals of facilitating curious questioning about clients' interests, attempting to engage them in *"that kind of childlike mode, 'What did you enjoy when you were a child?'" (Ruth).* However, participants believed this could reinforce feelings of depression when clients struggled to identify things which brought them meaning and enjoyment.

“Sometimes people can’t really connect with anything that’s felt good then, so pitching it in a way that doesn’t buy into people’s sense of depression that actually they feel they’ve never had anything to be happy about” (Ruth)

A few participants described that providing clients with a list of values could aid clients who struggle to identify things they enjoy.

“Often people can pick some things, it might be that they want to help other people or they like animals so once you’ve got at least one or two values then you could potentially look at how do we attach some behaviours to that?” (Ruth)

Behavioural Activation was described by several participants as most effective for clients when their personal values were considered within this.

“it does end up back at activity scheduling but often I find that it's it then more meaningful and the person's more motivated as compared to if you're simply just talking about routine and enjoyment and you know kind of necessary activities that they've disengaged with” (Alyssa).

Discussion

Summary

This study made unique contributions to the literature base exploring how therapists conceptualise change in CBT for depression, and how these beliefs shape clinical practice. The thematic structure revealed various perspectives regarding beliefs surrounding adherence to protocols, and conflicts experienced by therapists when making clinical decisions. Firstly, in response to the question of how therapists believe CBT for depression works, therapists described actively seeking to facilitate perceptions of themselves as

empathetic, honest, and hopeful. This was captured by Theme One. They believed this relational stance was itself a mechanism of change, aiming to counteract clients' negative relational histories and instil hope. Secondly, regarding what outcomes signal successful therapy, therapists reported a reconnection for clients with their personal identities and values. Alongside, shifting clients' self-perceptions from self-blame and criticism to believing that their difficulties are understandable in the context of challenging life experiences. This was captured within Theme 3. Thirdly, addressing what processes lead to these outcomes, therapists described the therapeutic relationship, longitudinal formulation, Socratic questioning, cognitive restructuring, and value based behavioural activation. These processes aimed to shift clients' self-perceptions and increase agency. They described navigating tensions when protocolised CBT was felt to conflict with these aims, such as believing directive CBT teaching could reinforce feelings of hopelessness. These findings were demonstrated by Themes Two and Three. Finally, in exploring how beliefs influence clinical practice, therapists conveyed conflicts between fostering client's agency by encouraging them to generate their own solutions, and their own impulses to introduce specific skills they believed to be helpful. They navigated this through collaborative scaffolding, depicted across both Themes Two and Three. Therapists also reported placing greater importance on the therapeutic relationship than they felt was emphasised in their CBT training, detailed in Theme One. These findings highlight how therapists' implicit working model shape their adaptations of CBT in real-world contexts.

Our finding that therapists actively seek to facilitate perceptions of themselves as empathetic, honest, and hopeful reflects theoretical literature postulating the therapeutic relationship as a primary change mechanism (Wampold & Imel, 2015). Alongside literature positing the therapeutic relationship as a reparative secure attachment bond for clients

(Mikulincer et al., 2013). Our study extends understanding, demonstrating that therapists work consciously to create and manage perceptions of themselves in the mind of their clients; a belief not reflective of standard CBT training. The findings identified that therapists shaped their relational stance because clients had recalled their therapists' voice when experiencing triggers, facilitating adaptive responses. This demonstrates how clinical experiences refine therapists' implicit working models (Nakash & Alegria, 2013; Bennett-Levy, 2006). Furthermore, the study identified that therapists believed being perceived as honest was foundational for cognitive restructuring. Believing that if clients did not hold this perception, they had no authority to facilitate alternative explanations for negative thoughts.

Therapists' emphasis on being seen as hopeful and confident in CBT's efficacy fits with the literature base showing therapist's belief influences client engagement (Bartle-Haring et al., 2022; Swift & Greenberg, 2012; Odyniec et al., 2017). However, this study adds nuance by exposing internal conflicts experienced by therapists when their private doubts diverge from the confident stance they present to clients. This tension is less explored by existing literature.

The analysis demonstrated that therapists endorse behavioural activation and cognitive restructuring as mechanisms of change, aligning with the research base positing these tools as fundamental (Jung & Han, 2024; Hollon et al., 2006). However, therapists felt these tools served to facilitate higher order goals of reconnecting clients with their personal identities and engagement with behaviours reflecting their values. These beliefs appear to overlap with third-wave CBT approaches such as Acceptance and Commitment Therapy (ACT; Hayes et al., 1999). Reengagement with meaningful activities has been proposed by

therapists of varying therapeutic disciplines as a change mechanism (Donald et al., 2018). Convergence between this study and ours may suggest that, across modalities, therapists believe this to be a valuable therapeutic goal.

The study also contributes to research on CBT adaptation (Bruijniks et al., 2018; Kendall & Frank, 2018) by illustrating that therapists also adapt their practice because of higher order goals, such as avoiding colluding with feelings of hopelessness, leading to less didactive skills teaching approaches and more focus on encouraging clients to generate their own solutions. These findings highlight that therapists' value experiential learning methods to balance the teaching of skills with client-led discoveries, a principle echoed in Donald et al. (2018).

Therapists' doubts about CBT's utility for clients presenting with co-morbidities or neurodiversity align with critiques of RCT generalisability (Rief et al., 2022; Snippe et al., 2019). The findings resonate with literature exploring factors that lead therapists to believe that CBT for depression protocols are harder to implement, or fit clients' needs less well (Snippe et al., Bruijniks et al., 2018). At the same time, therapists reported that witnessing CBT's effectiveness in practice supported their confidence in applying it. This illustrates how confidence evolves through reflective practice (Schon, 1983) and witnessing client outcomes (Odyniec et al., 2017).

While existing research does identify the development of insight as a mechanism of change (Jennissen et al., 2018), therapists in this study framed insight as a pathway to reduce shame and criticism, through revising negative self-beliefs. This supports cognitive theories of restructuring negative core beliefs (Hollon et al., 2006). However, nuance was developed within this study as to therapists' conceptualisations of the ethics of this

approach. They expressed concern that connecting current difficulties with past experiences may reinforce distressing narratives for clients about their histories. One therapist queried whether therapists risked presenting hypotheses, which make connections between past events and current life circumstances, as objective truths. This tension reflects ongoing debates in the literature regarding whether CBT-induced cognitive changes represent genuine changes to underlying cognitive predispositions, or are merely compensatory strategies (Hollon et al., 2006).

This study expands on findings by Tzur Bitan (2022), who identified therapists believed client motivation to be an influential therapy factor. Therapists in our study felt that stimulating motivation was an active part of their therapeutic approach. They described that, in depressive presentations, motivation is often compromised (Hohls et al., 2021). They seek to enhance this by reframing clients' difficulties from depictions of personal defectiveness to the results of psychological mechanisms which CBT can modify.

Finally, the study's findings both align and extend those from Delphi studies exploring consensus amongst experts regarding the importance of CBT components in the treatment of depression. Clinicians and experts by experience consulted in Yarwood et al. (2025) agreed most strongly on the importance of therapist qualities such as being non-judgemental, understanding and trustworthy. Our study adds nuance to this by revealing how therapists actively work to cultivate these perceptions in clients, consciously shaping the way they present themselves to enhance alliance, engagement and the delivery of re-appraising cognitions. Yarwood et al. (2025) identified that therapists, not experts by experience, believed behavioural activation, psychoeducation and homework to be central CBT components. Therapists in our study also identified these factors as significant and the

qualitative nature of the findings extends understanding. These components were described not as standalone techniques but as mechanisms to support broader therapeutic goals. Behavioural activation was framed as a means of reconnecting clients with valued identities, psychoeducation was depicted as a route to internalising CBT's belief system and developing agency to create change, homework was felt to foster clients' accountability to put changes into practice. The lack of endorsement from experts by experience highlights the importance of not assuming therapists' beliefs about mechanisms match those of clients. In relation to the Delphi study conducted by Taylor et al. (2020) our findings offer further support for the importance of developing and maintaining a strong therapeutic alliance, alongside providing a clear rationale for CBT. However, our participants asserted that these components are often used strategically to build belief in the therapy and therapist, implying that therapists do not only deliver therapy components but actively shape them in ways they feel enhance clients' belief in them and their therapeutic approach.

Strengths and Limitations

Recruitment was a strength of the study; the participant sample size yielded rich insight into how therapists conceptualise CBT for depression.

The application of a semi-structured interview and flexible topic guide was successful in revealing how therapists depict CBT for depression creates change in real-world clinical settings. The use of RTA allowed for identification of rich patterns between participants accounts. It supported exploration of layered themes, such as therapists facilitating views of themselves in the mind of clients, and therapeutic conflict. RTA led to a coherent and rigorous structure through which therapists' beliefs about CBT for depression, and its application in clinical practice, can be understood. Its emphasis on reflexivity allowed the

first author's positionality to be considered and enhanced analytic transparency. Braun & Clarke's (2022) 15-point thematic analysis checklist was adhered to, increasing the transparency of the research process.

A key limitation is potential selection bias of participants, those attracted to participate in the study may have been particularly confident or conflicted about their approaches. Participants beliefs and views may not have been representative of the wider population of therapists who apply CBT for depressive presentations. Additionally, the use of personal networks within the recruitment process may have resulted in bias. This may have led to individuals feeling particularly motivated to participate, or assuming their opinions will closely align with the research teams'. This approach to recruitment was undertaken in part as the project involved tight time constraints.

A limitation of the study is that participants' accreditation with the British Association for Behavioural and Cognitive Psychotherapies (BABCP) was not verified. Whilst they self-identified as meeting the inclusion criteria, lack of accreditation verification may have led to variation in training practices, and adherence to BABCP professional standards could not be ascertained. This may have influenced how participants conceptualised and implemented CBT.

Lack of consultation during the design phase of the study from individuals with lived experience of engagement with CBT for depression, or practicing clinicians, is a key limitation of the study. Consultation could have strengthened the study's relevance, sensitivity and practical application by ensuring that the research questions and interview schedule were aligned with real-world therapeutic observations and concerns. Consultation did not take place due to the tight time constraints of the project however input from

clinicians and experts by experience may have allowed for refinement in key concepts or highlighted areas for exploration not anticipated by the research team.

A limitation of the study was the difficulty in collecting accurate data on therapists' length of practice. Whilst all met the minimum one-year inclusion criteria, many were unsure of their exact experience. This limited the ability to present this data and explore potential relationships between years of practice, therapists' beliefs about change mechanisms and the importance of adhering to CBT protocols.

Use of an analytic approach such as Interpretative Phenomenological Analysis (IPA) may have allowed for deeper exploration of individual therapists' meaning-making processes. As the study aimed to understand therapists' internal conceptualisations of CBT for depression and therapeutic change, IPA could have offered greater idiographic detail and sensitivity to personal contexts.

Areas for Further Research

A recommendation for future research is a study which probes the conflicts therapists encounter in their clinical work. This study identified that therapists often hold multiple views which may not be internally consistent. A study could explore conflicts with therapists further, identifying if and how they are resolved. Gleaning further insight into how therapists' implicit working models function when faced with incongruent information from research, personal beliefs, service expectations, and prior clinical practice experiences.

A study which explores the beliefs of clients' who have experienced CBT for depression could be conducted. This may illuminate convergence and divergence in the beliefs of clients and therapists regarding the therapeutic approach.

Conclusion

This study provides insight into how therapists conceptualise change in CBT for depression, and how these beliefs shape clinical practice. Therapists described striving to facilitate a perception of themselves in the clients' mind as empathetic, honest, and hopeful. They felt the therapeutic relationship was itself a therapeutic mechanism, responding to the negative relational experiences of clients. The findings suggested therapists hold higher order goals such as restoring meaning within client's lives, fostering agency, and countering feelings of hopelessness. These aims sometimes led their practice away from protocolised CBT; demonstrating how therapists balance model fidelity with their own beliefs about what their therapeutic approach should do to create change. Therapists held conflicts regarding encouraging clients to reappraise distressing symptoms as results of negative past experiences. Raising concerns that this goal may inadvertently cause distress, or lead clients to overattribute difficulties to this new perception.

Importantly, therapists believed they must convey belief in the model to their clients, perceiving this to be paramount to facilitating change. The findings underscore the value of practice-based evidence in capturing the complexities of real-world application of therapy models.

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Tables and Figures

Table 1
Participant Information Table

Participant Pseudonym	Gender Identity	Job Title(s)	Current Client Population	Reported Therapy Qualifications
Alyssa	Female	CBT Therapist; EMDR Therapist; Clinical Supervisor and Tutor	Adult	Postgraduate Diploma in High Intensity CBT; EMDR Standard Accreditation
Carl	Male	Senior Clinical Psychologist	Adult	Postgraduate Diploma in High Intensity CBT; Doctorate in Clinical Psychology
Kate	Female	CBT Therapist	Adult - University Counselling Service	Postgraduate Diploma in High Intensity CBT

Laura	Female	High Intensity Therapist	Adult - Forensics	Postgraduate Diploma in High Intensity CBT; Masters in Counselling and Psychotherapy
Mariam	Female	CBT Therapist; Senior CBT Therapist for Training	Adult	Postgraduate Diploma in High Intensity CBT
Melissa	Female	CBT Therapist	Adult	Postgraduate Diploma in High Intensity CBT; Masters in CBT for psychosis
Nicola	Female	Counsellor	Adult	Postgraduate Diploma in

				High Intensity CBT
Paige	Female	Trainee Clinical Psychologist	Adult	Postgraduate Diploma in High Intensity CBT
Paul	Male	High Intensity Therapist	Adult	Postgraduate Diploma in High Intensity CBT
Ruth	Female	CBT Therapist	Adult	Postgraduate Diploma in High Intensity CBT; International Society of Schema Therapy Accredited
Sam	Male	Psychological Therapist	Adult	Postgraduate Diploma in

Tia	Female	CBT Therapist	Adult	High Intensity CBT; Postgraduate Certificate in CBT for Personality Disorders Masters in High Intensity CBT

Figure 1
Concept Map

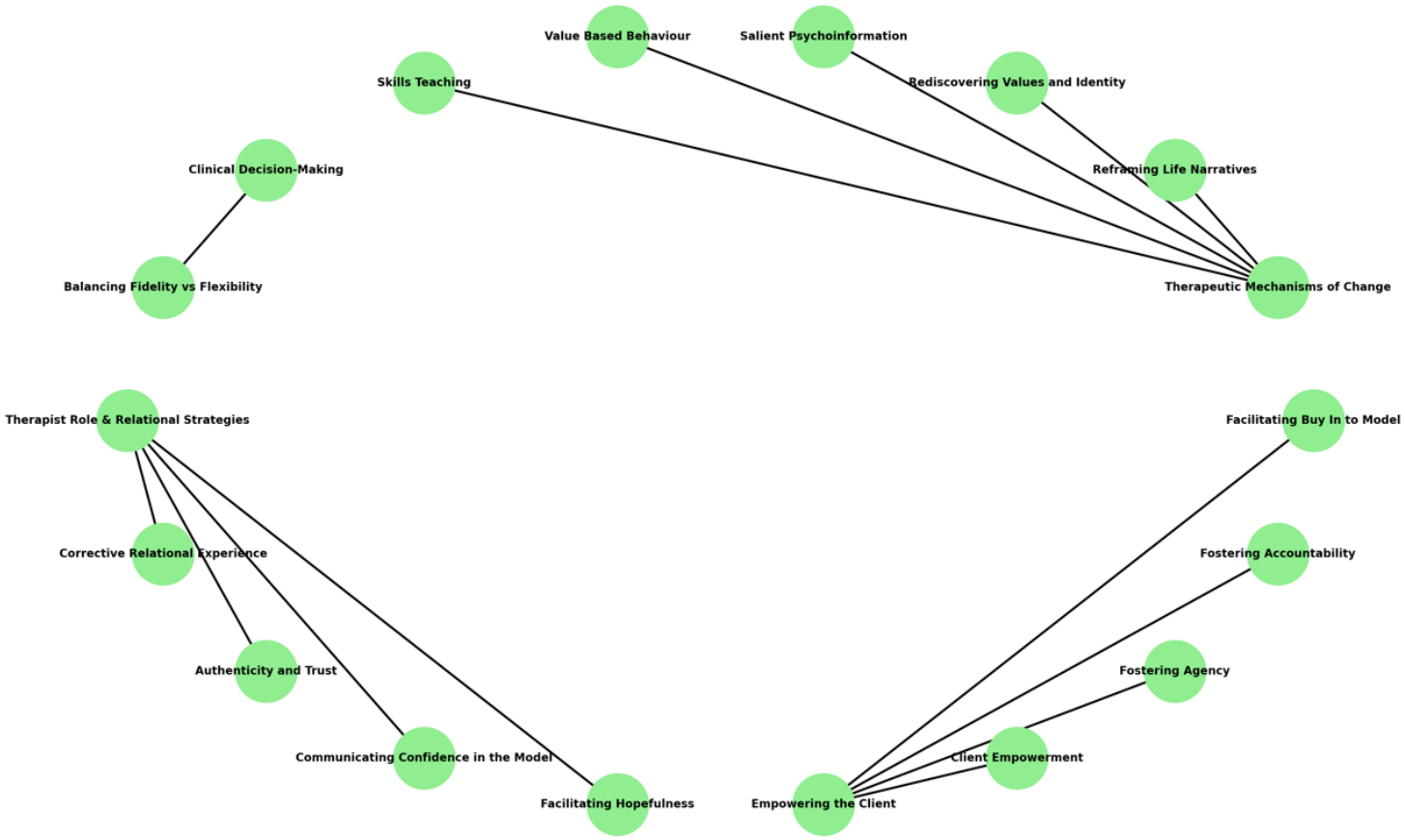
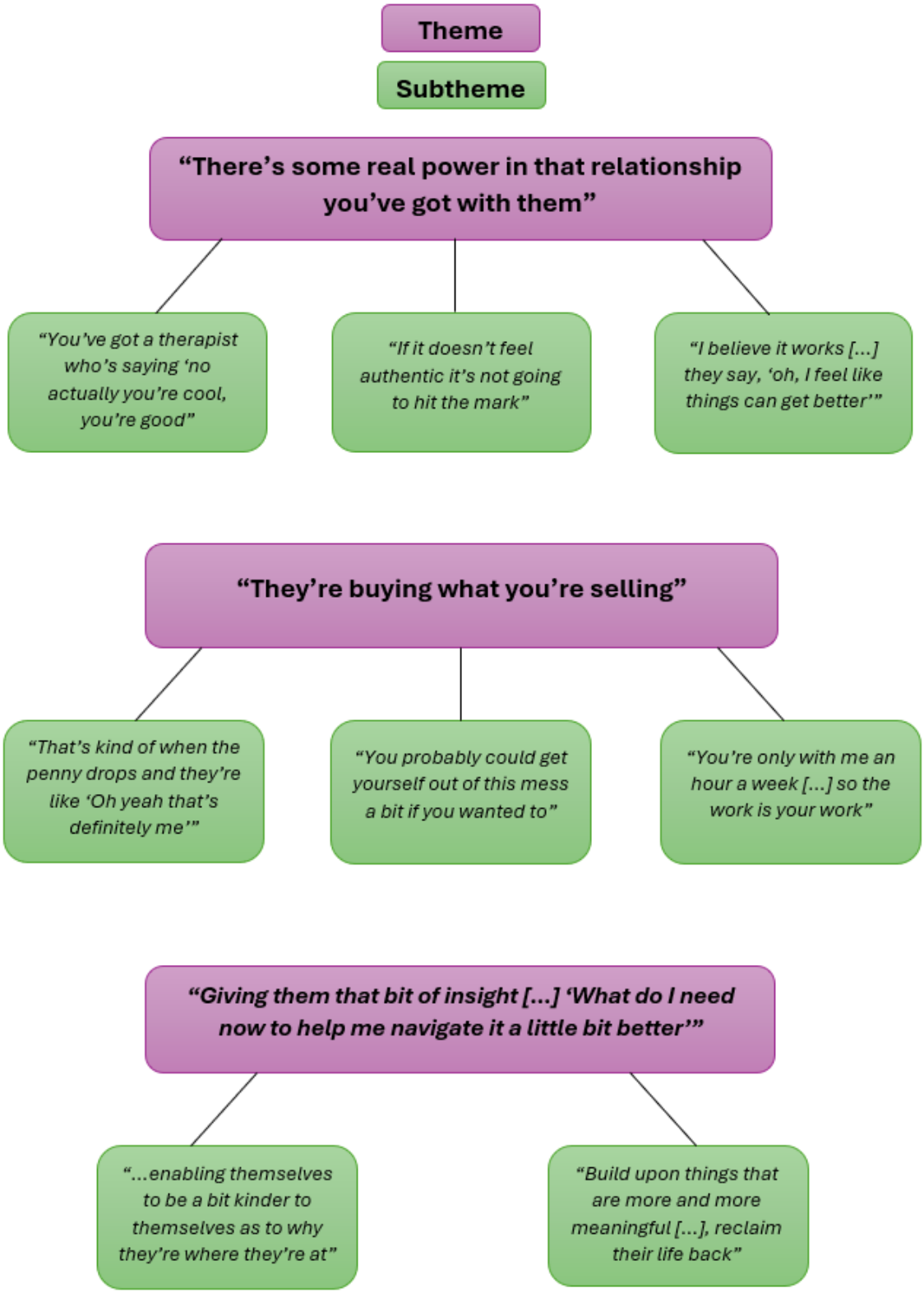


Figure 2
Thematic Map



Appendices

Appendix A

Research Poster

Doctorate in Clinical Psychology | Lancaster University

Research Study:

An investigation into the beliefs therapists have about how CBT for depression works.

My name is Olivia Johnson. I am a Trainee Clinical Psychologist at Lancaster University.

I am conducting a research study investigating how therapists believe CBT for depression works.

I am interested in what goals therapists are trying to achieve in their work, and how these beliefs impact on their clinical practice.

I am hoping your insight will help us to add to the research around how CBT for depression is used in clinical practice.

I would very much appreciate your input. I am keen to hear your views in a semi-structured 30-60 minutes interview, via Microsoft Teams.

I am hoping to hear from those who:

Have a job role of delivering psychological therapy.

Experience using CBT for individuals who report depression.

Use collaborative longitudinal CBT formulations for moderate-severe depression

Living, and practicing, in the UK.

Have one years experience within their role.

Please contact me if you are interested in participating, or if I can provide you with any further information:
o.johnson2@lancaster.ac.uk

Appendix B

Participant Information Sheet

Doctorate in Clinical Psychology | Lancaster University

Participant information sheet

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage:
www.lancaster.ac.uk/research/data-protection

An investigation into the beliefs therapists have about how CBT for depression works.

My name is Olivia Johnson, I'm a Trainee Clinical Psychologist at Lancaster University. I am conducting a research study investigating how therapists who have used CBT with individuals reporting depression think the therapy works. I am interested to find out what therapists believe are the important outcomes of therapy and how the therapy achieves this.

Please take some time to read the following information carefully before you decide whether or not you wish to take part.

What is the study about?
There has been much debate in research as to whether positive therapeutic outcomes happen mainly due to factors common amongst different therapy disciplines, such as a positive therapeutic relationship, or techniques specific to a therapy discipline such as cognitive restructuring within CBT. When asked, therapists have stated they believe both of these factors are important for achieving positive outcomes for their clients. However, little is known about what therapist's believe these factors or therapeutic techniques do, or what processes of change, they facilitate for their client.

This research aims to explore therapists' beliefs about what contributes to positive therapeutic outcomes in a more in-depth manner. It aims to focus on the use of CBT with patients who report they are feeling depressed. The study aims to focus on how therapists believe CBT works for those who are feeling depressed, what processes of change they are attempting to target in their work with individuals, and how these beliefs affect their practice.

Why have I been invited?
You have been approached because you are a psychological therapist who has experience of applying CBT with individuals reporting they are feeling depressed. I am interested to find out about your beliefs of how CBT works, what processes of change you are trying to create for clients, and how your beliefs impact your practice. The research team does not hold any existing ideas about how therapists will/should respond to these questions, and there are no right or wrong answers. Your insight would be very much appreciated.

To be eligible to participate in the study, the following criteria should be met:

- Have a job role involving the delivery of psychological therapy.

- Experience of applying CBT with individuals expressing a main difficulty of depression.
- A minimum of one years' experience within a psychological therapist role.
- Living, and practicing as a therapist, within the UK.
- English speaking.

What will I be asked to do if I take part?

Participation is completely voluntary. If you do choose to take part, we will arrange a time and date which is suitable for you to take part in an interview. You will be asked to provide informed consent via a consent form which will be sent to your email address, this should be retuned prior to the interview taking place. The interviews are expected to take from around 30 – 60 minutes. The interviews are planned to take place over Microsoft Teams. As the study does not hold any existing beliefs or assumptions on the topics to be discussed, it will take a semi structured format to make sure valuable insights and opinions are gathered from participants.

What are the possible benefits from taking part?
There are no personal benefits to participation, however, we are hopeful that your valuable contribution will allow for increased understanding of what therapy outcomes and processes therapists believe they are targeting in their work with clients. It is hoped that the study will contribute to further the research on how CBT for depression works in practice.

Do I have to take part?
Participation in this study is voluntary, and you are free to withdraw up to two weeks after the interview without giving any reason.

What if I change my mind?
You can withdraw your data up to two weeks after the interview takes place. In this case, I will extract any data you contributed to the study and destroy this. Data includes the information, views, ideas that you have shared. When interviews have been pooled together from multiple participants, it is often very difficult or impossible to remove data from a single participant. Therefore, 2 weeks is the maximum time frame in which you would be able to remove your data from the study.

What are the possible disadvantages and risks of taking part?
No risks are anticipated to result from participating in the study. If you do experience distress, you are encouraged to inform the researcher and make use of the resources which are provided at the end of this sheet.

The research team includes practicing therapists and as such recognise that being asked questions about how you believe therapy creates change might feel challenging. This area of research is fairly novel, and the team does not hold any preconceived ideas about right or wrong answers which participants could give. We are interested to find out any perspectives or ideas which people may have. If you do decide to participate in an interview, you can stop the interview at any time if it becomes uncomfortable or difficult.

Will my data be identifiable?

After the interview, only the researchers will have access to the data you have shared through your involvement in the study. All personal information, such as your name, will not be shared with anyone outside of the research project and will be kept confidential. Audio recordings of interviews will be destroyed after the data analysis process has taken place. Transcriptions will be pseudonymised.

How will my data be stored?

Your data will be stored in encrypted files, meaning only myself and my research supervisor will have access to them. These files will be stored on the Lancaster University approved file system, OneDrive, on a Lancaster University provided password protected computer. If you become a participant in the study, the Microsoft Teams interview will be recorded using the record feature of the software for transcription purposes. You will be asked some personal information during the interview, your gender identity and job description, which will be utilised in the analysis process of the study. During the transcription process your personal data will be extracted and stored separately from data generated from questions in the interview. These files will be password protected. The data will be pseudonymised so only the research team can link your personal data to the data generated from your interview. Immediately after the interview takes place the recorded interview file will be converted to MP3, meaning only the audio data of the interview will be retained. The video recording will be deleted at this point. After the data has been analysed, the audio recording will be deleted.

Lancaster university will retain your consent form, pseudonymised personal information and transcriptions of your interview for 10 years in accordance with research standards.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

How will we use the information you have shared with us and what will happen to the results of the research study?

The data you share would be used only for academic purposes, including my thesis and other publications such as publication in an academic journal. I may present the results of the study at academic conferences or practitioner conferences.

Direct quotes may be used in the written documents resulting from the study such as my thesis or in a published report. These quotes will be pseudonymised and therefore not identifiable.

What would happen if interviews raised professional practice concerns?

If the interview raised concerns regarding a participant's professional practice in their clinical work, such as indication that a participant could be abusing their professional power with the

client(s) they work with, the researchers would discuss this together in supervision. The research team would come to an agreement on whether the information is a concern of professional practice, and the appropriate action to take. Actions may include contacting the participant to discuss this further or breaking confidentiality to inform a professional body about the information.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

What if I have a question or concern?

We welcome any questions or queries you have about participating in the study. Please feel free to contact me, or my research supervisor.
Main researcher: Olivia Johnson **o.johnson2@lancaster.ac.uk**
Research supervisor: Dr James Kelly **j.a.kelly@lancaster.ac.uk**

Doctorate in Clinical Psychology, Health Innovation One, Sir John Fisher Drive, Lancaster University
Lancaster, LA1 4AT

If you have any concerns or complaints that you wish to discuss with a person who is not directly involved in the research, you can also contact:

Professor Steven Jones

Chair of FHM REC

Email: s.jones7@lancaster.ac.uk

The Spectrum Centre

Lancaster University

Lancaster

LA1 4YG

Sources of support

As part of the interview, we may discuss topics that are difficult for you and cause distress. If you feel you need further support the following resources may be useful:

- Samaritans Helpline (emotional support) 0847 909090
- Mind http://www.mind.org.uk/ 0300 123 3393
- The Samaritans https://www.samaritans.org/ 116 123
- Helplines Partnership https://helplines.org/helplines/

- Your GP

Thank you for considering your participation in this project.

Appendix C

Participant Consent Form

CONSENT FORM

Health & Medicine | Lancaster University

Project Title: An investigation into the beliefs therapists have about how CBT for depression works.

Name of Researchers: Olivia Johnson

Email: o.johnson2@lancaster.ac.uk

Please read the following carefully:

1. I confirm that I have read and understand the information sheet for the above study. ☐
2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I withdraw within 2 weeks of commencement of the study my data will be removed. ☐
4. I understand that any information given by me may be used in future reports, academic articles, publications or presentations by the researcher/s, but my personal information will not be included and I will not be identifiable. ☐
5. I understand that my name/my organisation's name will not appear in any reports, articles or presentation without my consent. ☐
6. I understand that any interviews will be audio and video-recorded and transcribed and that data will be protected on encrypted devices and kept secure. ☐
7. I understand that data will be kept according to University guidelines for a minimum of 10 years after the end of the study. ☐
8. I understand that if the researcher identifies in interviews that I am potentially engaging in professional misconduct, this will be discussed by the research team in supervision and an appropriate action will be identified. This may include the research team breaking confidentiality to inform a professional body of the information. ☐
9. **(Optional)** I consent to my email address being stored by the research team in order for a summary of the study's findings to be emailed to me after the study is complete. This data will be stored on an encrypted device and deleted after the summary has been sent. ☐
10. I agree to take part in the above study. ☐

Name of participant:	Date:	Signature:

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Signature of Researcher/person taking the consent _____

Date _____ DD/MM/YYYY

V2

One copy of this form will be given to the participant and the original kept in the files of the researcher at Lancaster University

Appendix D

Interview Schedule

Doctorate in Clinical Psychology | Lancaster University

Semi-Structured Interview Topic Guide

This document serves as an internal guide for the research team to conduct interviews and will not be shared with participants. It outlines the key areas which will be covered during the interviews.

Below are sample questions that may assist in this process. These questions and topics will be used flexibly, and the interviewing style will be adaptive, depending on the conversation in line with the research questions. These topics are also subject to change based on the first interviewees responses.

Opening

- Begin with introductions.
- Clarify the study's purpose and goals: We are here to discuss your beliefs around how CBT for people reporting depression works, I'm interested to find out how these beliefs inform your practice.
- Discuss the interview's duration: I anticipate the interview will last between half an hour to one hour, please let me know if you need a break or prefer to continue at another time.
- Express that there are no right or wrong answers, the questions might lead to a point where they don't have further information to give and this is fine. Let them know they are able to tell me if this is uncomfortable or they would like to stop.
- Remind participants to uphold the confidentiality of their clients.
- Clarify consent to continue.

Personal Information

- What is your gender identity?
- What is your job title?
- How long have you been within your job role for?

Topic 1: How does CBT for depression work?

- How do you believe CBT for depression works?
- What aspects of CBT do you believe are beneficial for people reporting depression?
- How do you believe CBT creates positive change for people reporting depression?
- How do you know when CBT is working/not working for someone reporting depression?
- When do you decide to make adaptations to a CBT model for depression?

Topic 2: Finding out about beliefs in processes of change

- *If a participant mentions techniques they use in therapy, such as behavioural activation*: "What do you believe doing that does for the client?" "What processes do you think take place because of X?"
- *If a participant mentions non-specific factors they use in therapy, such as facilitating a strong therapeutic alliance*: How do you think X creates change for someone?
- How do you think X which you do in therapy affects someone's life outside of the therapy room?
- How do you think X supports people to feel less depressed?
- How do you decide when it seems like the techniques you are using aren't creating a change for someone? What sense do you make of that?

Topic 3: Effect of beliefs on practice

- What effect would you say that belief has on your practice?
- How do you try and facilitate that change process in your sessions?
- What techniques do you use to support X happening?

Supplementary information questions

- Do you think it is important for therapists to know how the therapy they use works?
- What attracted you to take part in this research?
- What was the experience of being asked these questions like for you?

Appendix E

Debrief Sheet

Doctorate in Clinical Psychology | Lancaster University

Debrief Sheet

Checking in

- How did you find the interview?
- How do you feel?

Thanks

- Thank the participant for taking part and recap how their contributions will hopefully help to make sense of what therapists' beliefs are about how therapy works and understand how therapy works in practice.

Next steps and right to withdraw

- Inform participants that their data will be transcribed and anonymised.
- Remind them they have 2 weeks to withdraw from the study if they wish to.
- (If indicated on consent form about consent to provide summary information after data analysis) Let participant know they will be emailed a summary of the findings after analysis takes place.

Follow up/ places for support

- Ensure they have my email address – encourage them to make contact if any questions or concerns arise as a result of participating in the study.
- Remind participants that there are sources of support available on the participant information sheet if they wish to use them.

V1

Appendix F

List of Initial Codes

following what's meaningful to the person

impact of time limits and session numbers

the limits of CBT services in offering support

formulation as creating links with past and present

integrative approaches

bringing in other approaches

role of CBT to upskill people for the future

BA as a primer to cognitive

formulation as making sense of self-blame and applying this in present

CBT not well adapted for culture neurodivergence

therapist own experience impacting practice

CBT is not for everyone

impact of training on practice

development of awareness or insight

CBT can be reductionist

signs that CBT is not having the intended effect

formulation as sensemaking

CBT is not a talking therapy it's a doing therapy

therapist role of increasing problem solving

CBT tools as invalidating

Beliefs about CBT

BA as increasing motivation

connecting the past with the present

goals of helping adjustment

people as individuals

formulation as identifying where things can change

adaptations to fit client

psychoeducation to normalise

outcome measures to assess for change

complex life circumstances create barriers

identifying barriers to engagement and planning a response

therapists' belief in a model rubs off on clients

Newly qualified stick to training teaching

changing practice to fit presentation

developing insight causes strong emotions

impact of expert therapist role

letting service users decide what is helpful

goal of lifting client's mood

TA

TA as modelling compassion to meet unmet needs

goal of increasing meaningful activity

goals to track progress

CBT as upskilling

BA as distraction rather than tackling root cause

being authentic and transparent builds trust and collaboration

stigma of CBT

Importance of buy in

insight as having a real-world impact on relationships

insight as having complex consequences

formulation as making sense of the past and reducing self-blame

formulation as creating awareness in the present

formulation as a hypothesis

therapy itself creating a cognitive bias

CBT as problem focused

the therapeutic relationship means asking questions you wouldn't be asked by other people

protocols lead to missing important bits for people

is it important to know how therapy works

identifying their goals

TR as not colluding with should and shouldn't

TR allows for agency and choice

protocols work for low level cases

protocols are hard to implement with more complex cases

protocols as inflexible

TA more important than protocol

TA meets unmet emotional needs

behaviour as an observable outcome

comorbidity

formulation creates insight which leads to choice

therapist job of operationalising goals

cues from the client demonstrate outcomes

engagement demonstrates effectiveness of intervention

aim to reduce risk

importance of flexibility

limitations of protocols and inflexibility

BA for severe depression when someone can't engage in cognitive work at that time

therapist job to pace the work

TA as a unique relationship

therapist job of holding people accountable to change

therapists past experiences influencing practice

TR as therapeutic in itself

goal of increasing insight

Process of helping someone take a step back without being swept away by usual thought patterns

Ah Ha moments from realisation that reality doesn't match up with predictions

flexibility allows to follow what's meaningful for the person

Training is impacted by other people's preferences

service users receptive to behavioural activation

SU expectations of CBT

applying cognitive increased validation

researching when noticing needing to change practice

cognitive as more in depth

Building up TA makes people more receptive to the heavy stuff

connecting the past with current thoughts about self, world, others

outside of session work as continuing awareness and insight work

importance of collaboration in sensemaking

manualised CBT as not adaptive to individual needs

changing practice to stop CBT feeling reductionist

identifying existing strengths

changes noticed for someone

CBT as internalising therapists voice

CBT as developing ability to take a step back and notice assumptions in thoughts and feelings in present

CBT as inflexible

beliefs about sticking to the model

importance of collaboration

views and approaches change over time

considering the aetiology of depressive episode

depression as stuckness

role of expectations in depression

self-esteem in depression

insight allows for agency and choice

realigning with wants

TR as unique

Talking therapies services as inflexible

link between mood and activities and sense of purpose

formulation as making sense of stuckness

making outcomes or goals led by service user

therapist job of guiding someone to self-discovery

homework tasks to connect dots and identify areas for change

therapists' belief in model

service impact on goals

therapist personal preferences

finding ways to hold someone accountable to change outside of the therapy room

feedback from clients to assess change

aim to improve daily functioning

therapist as offering a helping hand when the world is hard

importance of knowing how CBT works

my goals are secondary to the clients

some clients will always have a high baseline measure of depression

goal of doing a good piece of work for the client

their goals are my goals

wider toolkit in CT over BA

Cognitive allows for understanding of situation and then for people to make change to

the situations causing repeated patterns of negative core beliefs

therapist role of holding emotional weight whilst client makes difficult self-discoveries

therapist as cheerleading client

formulation as painful

TA just as important as intervention

TA challenges negative self-beliefs

more scaffolding at early points in intervention

services set up for lower levels of severity which don't match up to present day

thorough assessment is key

goal of empowering people

collaboration is something that has not been experienced in past life events for some people

collaboration to keep things from being overwhelming and scaffold confidence

importance of explaining rationale of BA - links between mood and activity

BA as trying to increase choice in other actions

importance of people having their own experiences which matchup to the info you're telling them

importance of continuous review of how the therapy is going

if someone doesn't complete homework might be a sign that intervention is not being helpful for the person at that time

building up TA and collaboration makes people more receptive to suggestions

TR can instil hope

TR and trust make someone more likely to try what is suggested to them and increases buy in

therapists can repeat interpersonal trauma

making things person specific

BA as responding to cognitive difficulties in severe depression

difficult life experiences recalibrate reward punishment circuitry values-based activities respond to this

amount of reflection on therapy demonstrates outcomes

formulation as validating

TA as responding to marginalisation of depression in wider society

exploring the root cause of low mood

therapist role as encouraging reflection

training draws attention to areas where CBT might fall down

increased complexities in services that CBT was not set up for

longitudinal CBT depression formulation has room to consider other presentations in it

bottom-up approach in formulation starts at maintenance and work up to beliefs

formulation as motivation to do something differently

complex presentations may mean CBT for depression isn't getting to the root of the difficulties

BA an indirect root to cognition

depression model as broad and flexible

belief in model relates to the outcomes you're seeing

transparency allows for review of how therapy is going

TA as modelling transparency and honesty

potential to pick the wrong model

adapting tools to fit client group circumstances

therapist providing hope to clients through their belief in the model

behavioural activation

feeling behaviour connection

Changing someone's behaviour

service users understanding rationale for behavioural activation

CBT as work

explaining the evidence and rationale for intervention

BA as basic with knowledgeable service users

repetitiveness in therapy system

content of sessions not meeting people's expectations

importance of confidence when using interventions

core beliefs as heavy and requiring work beforehand

Developing TA before moving onto heavy work

using simple bits as part of the TA build up

cognitive work brings more lightbulb moments than behavioural

cognitive work as emotive

self-blame as central in depression

CBT increasing psychological mindedness

Goal of facilitating people to have questions in the back of their mind

behavioural work sets people up to carry on after therapy manual approach

how it feels to be asked these questions

difference in expectations to reality creates stuckness

goal of helping to make sense of things

goal of identifying where stuckness is in relation to goals

insight plans next steps

values and beliefs mismatch

stuckness

encouragement to think about other options reduces stuckness

role of validation

self-disclosure as normalizing

experience increases flexibility

TA as internalising therapists voice

adaptations to align to therapists' own values

link between relationships and mood

realigning with values

treating rumination as a behaviour

CBT process of reducing the behaviour of rumination

protocol important because its evidence based

when to switch from protocol

using different approaches but keeping CBT aetiology

changing protocol to meet someone where they're at

feeling heard

catharsis

choosing a formulation template that fits

collaborative formulation

impact of formulation

formulation as continuous

formulation creates change

formulation increases motivation

formulation monitors change

outcomes need to be specific

outcomes need to be meaningful for someone

therapy process as self-discovery and scaffolding this for a person

goal of CBT is to apply this to the rest of life

The therapy room as planning the outside work as enacting change

trying to facilitate self-awareness

therapist job to plan as depression comes with lack of motivation and cognitive slowness

increased ability to plan demonstrates improvement

structure of CBT itself makes people more proactive in problem solving

CBT tools to increase insight

CBT tools to reduce self-blame

BA links to self-identity

understanding how a therapy works allows you to pick the right bits for the person

psychoeducation isn't novel information sometimes but still helpful

psychoeducation makes the penny drop

psychoeducation demonstrates stuckness

psychoeducation creates change through destigmatising what's going on for a person

using formulation to assess for outcomes throughout the intervention

psychoeducation to explain treatment rationale

BA to reconnect with pleasure or mastery

therapist job of working towards a goal

requirement to feedback on BA activities help to create accountability

therapist job of finding ways to hold someone to accountability to change in between sessions

protocols as highly structured

BA activities as working on depression through clearing brain fog and increasing concentration

clinical practice aligning with training

clinical justification for deviations

different protocols aren't reinventing the wheel

psychoeducation to increase buy in

things that might explain seeming lack of effectiveness

change methods to demonstrate outcomes

change in beliefs demonstrate clinical progress

challenging amount of belief in a thought and seeing change in that belief demonstrates improvement

therapy itself lays the groundwork for change which will take a long time to take place

change in core beliefs impacts on everyday living

keeping client goals as the main focus

aim that depression CBT will impact other difficulties too

providing skills to target change in cognitive processes

therapist as operationalising skills to cope in the future

therapist as preparing client to use the therapy themselves moving forwards

therapist recognition of the complexity and time-consuming nature of CBT skills

following what's meaningful to the person makes them use it outside of the session

formulation includes accountability for own part to play

wanting to understand self and situation is a reason people come to therapy

if therapy facilitates insight this transcends the therapy itself

when insight isn't developed in therapy clients return

CBT is a middle-class white therapy

CBT is academic and jargony

feelings of self-blame when CBT doesn't work for a client

CBT training as unclear in flexibility

sticking to protocol may demonstrate lack of understanding around how to help someone

CBT training doesn't consider therapists own views

real life clients are very different to training cases

preference for cognitive therapy

putting your heads together to work out goals

IAPT outcomes as reductive

client goals are more important than service goals

goal of making life more enjoyable for client

less experience means trying to get a square peg to fit this round hole

focus on service goals takes you further away from the clients

service expectations as dancing to someone else's tune

real life clients are complex and sticking to service expectations is not possible or helpful

service users rely on therapist expertise to guide treatment sometimes

evidence base as changing and unsubstantiated

putting your heads together to work out treatment

BA as quick for clients to understand

BA as simplistic

CT as pulling weeds out at the root

noncollaborative formulation can be a horrendous experience for the client

formulation as making sense of difficult self-beliefs

CBT training as not always thinking about how sensitive some of the work is

TR should not be a comfortable one it should challenge you

formulation is a means to an end

insight has the ability to create long lasting change

importance of being honest with client about the difficulties of insight

insight creates long lasting seismic changes

therapist as villain of insight

evolutionary concept of developing shared trust with client

CBT teaching underplays the importance of therapists holding the client

therapist role of not guided self-discovery but taking a lead to walk the client through painful bits

more didactic for severe depression as struggle to problem solve and feelings of overwhelm

self-report of client to measure change

service goals are not achievable with all clients considering context of current climate

complex presentations in Talking Therapies services

being too directive colludes with hopelessness and helplessness of depression

BA in a way which is not overwhelming

collaboration to target worthlessness

targeting empowerment through jointly working and giving agency

targeting empowerment through making sure people understand the work

people feel worse when they don't have a clear rationale for why they are doing something

BA getting people to see the knock-on effects of their actions

BA as increasing hope through demonstrating there are other options

When people start connecting the model to their own experiences this demonstrates the intervention is being helpful

targeting insight

formulation to provide something which someone can draw whatever conclusions from which they resonate with

when someone decided for themselves where to start working from the formulation this demonstrates change

severe depression may mean someone relies on therapist to make decisions more

when people aren't able to take part this suggests the model isn't helpful

lowering of mood and increased risk demonstrate the therapy might not be helpful for that person

setting goals too high can cause problems

difficult weeks for the client can lower engagement in therapy

managing expectations of clients and that change takes time

goal of helping clients to identify and question NATs in their daily lives

goal not to eradicate depression but to give ways of managing and keeping agency when they are struggling

recognising NATs through thought challenging, identifying thoughts, mood and thought tracking

CT not suitable when someone is highly depressed

pleasure achievement and connection as important for all humans

importance of being individual with approach

BA asking questions about previously enjoyed activities can feed into someone's sense of depression if not done well

values helpful for people who struggle to identify what they enjoy

potential to be more directive when you know someone well

being authentic responds to negative relational experiences people have had in their lives

recognising the power imbalance and how this may reenact past experiences

therapy can recreate negative past experiences therapist job of empowerment in reframing narratives through actions

power of therapists and importance of recognising this in what we ask people to do and how difficult it may be

authenticity more important than therapeutic skill

TR as a response to the negative relationships in the past which they can take forwards

responding calmly and formulating risk

protocols are quite formulaic

seeing change in the person is more important than knowing how the therapy works

BA to reduce symptom severity

BA to increase motivation

BA as a primer to thinking more about a person's values and empowerment

meeting people where they're at in values

helping to identify what is important to someone and how this can be practiced

values based activity scheduling better as more connected to the person and more meaningful

reviews to monitor outcomes

perception of TA relates to progress in therapy

outside of session work suggests people are finding the therapy useful

poor TA leads to drop out and reexperience of negative relational dynamics

TR as monitoring progress

making agreements to monitor for change

therapy requires a lot of cognitive thinking and time

internal reasons create barriers for people

when emotions connected to core beliefs are so strongly held CBT may not be the right approach

formulation is necessary

cognitive formulation

formulation as taking a step back and not be swept along into patterns

TR showing genuine care and increasing hope

formulation as challenging the way people conceptualise themselves as people

scaffolding responds to brain fog and exhaustion in depression

Socratic questioning increases learning as it encourages someone to think for themselves

which uses different part of brain

repetition increases buy in as shows the importance

therapist role of making sure someone understands what they have been asked to do

and why

reviewing homework as demonstrating the alliance

allegiance to a model

service pressures that don't align to the presentations seen

reflections on practice

often someone is not just experiencing solely depression

goal of reducing distress and improving functioning

letting clients know that change takes time

targeting hope

aim of improved motivation

increased enjoyment appears to be a late change process

aim to increase enjoyment

reducing physical symptoms

aim to change thinking

CBT as spinning plates

therapist job of working out what a good starting point would be for change

therapist job of identifying what experiences have led to the presentation

formulation to target hope

formulation as empowerment

formulation as empowerment through hope

managing transference of hopelessness

referring back to the formulation when things take a step back in therapy as a reminder of hope

therapist role of getting clients to think about and recognise the changes they have made

increased flexibility in thinking demonstrates outcomes

increased engagement in therapeutic process demonstrates outcomes

increased ability to challenge thoughts in the moment rather than retrospectively demonstrate outcomes

clients taking on Socratic questioning in situations demonstrates improvement

internalising therapists voice as improvement

process of rewiring brain

therapists' feelings when CBT does not seem helpful

training might not align to clinical practice findings

substances might impact on CBT effectiveness

service users must be sold on the intervention to believe it will affect change for them

the accountability of the therapeutic relationship can respond to the lack of motivation in depression presentations

goal of clients internalising the accountability to the therapist they feel to complete tasks to themselves

formulation as creating a sense of accountability

using strengths-based approach to target accountability

therapist role of identifying concrete skills to fill in gaps

structure of CBT sessions to increase accountability and problem solving

encouraging experimentation with self

experiments are important to actually put into practice what has been spoken about or cognitively worked on to test assumptions or beliefs

encouraging reflection to gather evidence for alternative ways of thinking

protocol important as you're formulating from it

pulling in bits from other places when it fits with the formulation

complexity might mean things take more time

therapist role of upskilling so people can choose skills which problem solving

adding things to the agenda shows change

trying to fit skills in in a natural way

belief in model fluctuates

facilitating hope through letting clients know about good outcomes

creativity in protocol due to population

CBT for depression as a tolerance building model for depression

NATs as something applicable to everyone

depression formulations as client friendly

formulation to normalise

formulation might alleviate secondary emotions

normalisation helps people to feel less isolated

psychoeducation can respond to the isolation and loneliness of depression

psychoeducation to create links

goal of increasing flexibility in thinking

goal of someone at least being aware and understanding of their core beliefs and the impact

goal of symptom reduction

goal of more balanced routine

adapting tools so people make use of them outside of the therapy room

therapist job of encouraging home practice of skills

balance between giving skills and not telling what to do

relationship makes people more likely to take onboard advice and tools

collaboration to manage therapist pulls

collaboration asserts client's responsibility

collaboration and accountability lead to long lasting change

therapist may be more directive initially and expect this to reduce

CBT as passing the baton of skills to client

increased activity demonstrates change

mood check ins demonstrate change

when a trigger is experienced there's opportunity to assess change

downward arrowing to assess change

transparency is key for thought challenging

deciding between BA and CT

BA 10 minute rule

BA difficult in forensic environments at times

formulation as a visual representation of something that feels messy

formulation helps to make sense of messiness

importance of personalised psychoeducation to facilitate understanding

the importance of allegiance to a model not overriding clinical rationale

core beliefs work as managing entrenched depression

goal of people not returning to therapy

aim to provide the substance for people to continue independently or top in in smaller ways

behavioural experiments to improve functioning

using timelines to explore where core beliefs come from

outcome measures to identify core beliefs

prediction sheets to track change

buy in to treatment helps people apply things they logically know in practice

giving agency through not taking the expert role and instead giving ideas of skills

transparency as dispelling myths of psychology as a magic wand

power imbalance will lead people to keep coming back to the expert

CFT to frame accountability

talking about barriers to increase agency

encouraging responsibility for change through compassion

therapy as a continuous process after sessions end

transference of hope to clients through therapists

therapist job of managing stuckness and facilitating hope

importance of engagement

service users need to understand to engage

Appendix G

15-point Thematic Analysis Checklist (Braun & Clarke., 2022)

No	Process	Criteria
1	Transcription	The data have been transcribed to an appropriate level of detail; all transcripts have been checked against the original recordings for 'accuracy'.
2	Coding and theme development	Each data item has been given thorough and repeated attention in the coding process.
3		The coding process has been thorough, inclusive and comprehensive; themes have not been developed from a few vivid examples (an anecdotal approach).
4		All relevant extracts for each theme have been collated.
5		Candidate themes have been checked against coded data and back to the original dataset.
6		Themes are internally coherent, consistent, and distinctive; each theme contains a well-defined central organising concept; any subthemes share the central organising concept of the theme.
7	Analysis and interpretation – in the written report	Data have been *analysed* – interpreted, made sense of – rather than just summarised, described or paraphrased.
8		Analysis and data match each other – the extracts evidence the analytic claims.
9		Analysis tells a convincing and well-organised story about the data and topic; analysis addresses the research question.
10		An appropriate balance between analytic narrative and data extracts is provided.
11	Overall	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase, or giving it a once-over-lightly (including returning to earlier phases or redoing the analysis if need be).
12	Written report	The specific approach to thematic analysis, and the particulars of the approach, including theoretical positions and assumptions, are clearly explicated.
13		There is a good fit between what was claimed, and what was done – i.e. the described method and reported analysis are consistent.
14		The language and concepts used in the report are consistent with the ontological and epistemological positions of the analysis.
15		The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

Retrieved from Braun, V., & Clarke, V. (2022). *Thematic analysis: a practical guide* (1st edition.). SAGE Publications Ltd.

Section Three: Critical Appraisal

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Process of Appraisal

This critical appraisal aims to summarise personal reflections and observations I noted in a journal throughout the process of completing the research study, and systematic literature review, of this project. Keeping a record of my thoughts and perspectives helped me to remain aware of potential influences and biases that could affect my engagement with the project. It also supported the identification of limitations, encouraged reflection on possible avenues for future research, and allowed me to consider how my learning from this project may shape my future clinical practice.

Summary of Research

Both papers within this project focused on deepening understanding of psychotherapy, by exploring the perspectives of those directly engaged in the therapeutic process, service users and therapists.

The systematic literature review synthesised first-hand accounts of individuals who experienced an ending from an individual psychotherapy. Sixteen studies were identified as meeting the inclusion criteria, and a meta-ethnography approach was taken to data synthesis. This process yielded two overarching constructs, of which service users' experiences of psychotherapy endings could be understood: Cohesion within the Ending Process, and Personal Agency within the Ending. It concluded that service users' perceptions of interactions between themselves and their therapist, alongside the amount of control they believed they had regarding the ending, were highly important factors.

The research paper focused on exploring what psychotherapists who apply CBT for depression believe about their therapeutic approach. It specifically aimed to investigate their points of view regarding how the therapy works, what outcomes constitute successful therapy, what processes facilitate these outcomes, and how these perspectives impact their clinical practice. Twelve therapists took part in semi-structured interviews to gather this data. A Reflexive Thematic Analysis (RTA) was utilised to identify patterns across the dataset. Three themes were developed: “There’s some real power in that relationship that you’ve got with them”, “They’re buying what you’re selling”, and “Giving them that bit of insight […] ‘What do I need now to help me navigate it a little bit better”. The paper concluded that therapists aim to be viewed by clients as empathetic, honest, and hopeful, viewing the relationship itself as therapeutic. They balance CBT fidelity with clients’ needs, attempting to restore agency and reconnect clients with their values, whilst navigating tensions between protocols, personal beliefs, and therapeutic complexities.

Together, the papers highlight psychotherapy as a nuanced relational and meaning-making process. The papers have a shared emphasis on agency within the therapeutic process, and interpersonal connection within the therapeutic relationship.

Areas of Appraisal

Within this critical appraisal I focus on reflexivity. I consider how my experiences, perspectives, and positionality shaped my engagement with the project, reflecting on the benefits and limitations of these factors. I discuss the limitations of the project, summarise how my reflections may inform future research, and consider its impact on my personal clinical practice.

Reflexivity

Background Influences of the Project

The initial idea for the empirical research study was to conduct a case series exploring the acceptability and feasibility of using Method of Levels (MOL; Carey, 2006) Therapy with individuals experiencing suicidal thinking. I was drawn to the topic partly because I knew that working with suicidality can provoke avoidance and aversion amongst therapists (Knapp et al., 2024). I believed a project focused on providing intervention for this service user group would benefit my clinical competence. I also wanted to provide a meaningful contribution to an underdeveloped area of practice, there remains a lack of evidence-based psychological interventions for suicidal thinking (Agency for Healthcare Research and Quality; AHRQ, 2025). I developed the research protocol and submitted the required study documents to the Lancaster University Research Sponsorship team. However, the process of operationalising this study proved extremely challenging. Ethical concerns around risk management created barriers to progressing with the project. This experienced prompted me to reflect that the ethical processes involved in research, although necessary, at times appear to unintentionally mirror the same risk-adverse behaviour of clinicians. In July 2024, following a meeting with my research supervisors, we agreed that the original project was not feasible within the time I had remaining on the doctorate. The experience made me reflect on the acknowledgement that, despite their training within the scientist-practitioner model, clinical psychologists' engagement with research is limited (Smith & Thew, 2017). I began to consider whether structural barriers, such as the ones I encountered, contribute to this issue.

Following this, I worked with my supervisors to determine a new direction for the research study. Given our shared interest in MOL therapy, which is based on Perceptual Control Theory (PCT; Powers et al., 1960), the subsequent focus was influenced by this research area. For context, PCT posits that human behaviour results from attempts to maintain control by reducing discrepancies between experience and internal reference values. Psychological distress arises when these internal values conflict with each other. MOL responds to this by encouraging clients to explore these conflicts through open-ended exploratory questions, aimed at increasing awareness and enabling resolution. My field supervisor had completed a scoping review (Carey et al., 2020) which concluded that no existing studies provide a functional explanation of how psychotherapy works, thus what processes therapists are attempting to facilitate through their work with clients. The team's shared interest in process-orientated theories of change such as PCT, and subsequently MOL, shaped discussions around this gap in understanding. Consequently, the rationale for the current study was arrived at; to explore how therapists understand the purpose of their practice, what mechanisms they were attempting to facilitate for their clients and how their impacts on their clinical practice.

In shaping our data collection strategy, inspiration was drawn from the conversational, curious, and open-ended questioning style implemented by MOL therapists. We did not formally apply these questioning styles to interviews; however we were interested in how therapists' narratives may reveal tensions in their understanding of how their therapeutic approach creates change.

Positionality as a Trainee Clinical Psychologist

Within the data collection process of the research study, my position as a Trainee Clinical Psychologist had several implications. My professional identity was perceived by participants as aligned with their own at times during the interviews. Several participants explicitly inferred my clinical background, often assuming that I was aware of aspects of the therapeutic approaches and techniques they described. Some followed up explanations with comments such as “You probably already know this”. In some cases, they questioned whether further elaboration was necessary, suggesting an assumption of shared professional understanding. Participants frequently referenced challenges in public mental health settings, such as service pressures and increasing service user complexity. They often commented that I’d likely experienced these firsthand.

I sought out literature exploring the role of clinician-researchers to help make sense of my experience and consider the potential impacts of my positionality on the study. I came across an article aptly named “Experiences of an insider researcher – interviewing your own colleagues” (Aburn et al., 2024). While focused on nursing research, the name of the article resonated deeply with my experience. The content connected with my experiences; my position appeared to facilitate rapport through professional kinship. It seemed to be a cathartic experience for participants at times, offering an outlet for reflection on practice. Despite this, my proximity may have introduced potential biases of over-identification, confirmation bias, or collusion with participants’ perspectives (Dwyer & Buckle, 2009). I did notice a heightened emotional attunement when participants discussed the emotional toll of working in services they experienced as under resourced. Descriptions of conducting therapeutic work with complex populations resonated with me, and I occasionally felt a pull to provide peer support rather than maintain an analytic stance. This feeling was particularly strong in moments where therapists expressed doubts about their

capacity to create change for clients who faced high levels of social adversity. One therapist explicitly expressed believing that depression was a highly understandable, perhaps healthy, response to these difficulties. These conversations mirrored my own professional concerns and resulted in a personal sense of hopelessness at times. Ironically, echoing the tensions participants described between facilitating a sense of hope for their service users despite their wavering internal beliefs. This highlighted a recursive dynamic between researcher and data.

My experiences preparing for data collection also shaped my interpretative lens. When piloting the interview schedule with a peer, I asked them to interview me about my own therapeutic approach. This illuminated the potentially exposing nature of the interviews. Subsequently, it heightened my sensitivity to the possibility that participants may feel scrutinised or professionally challenged. Consequently, I incorporated an explicit introductory statement into the interview schedule, emphasising that there were “no right or wrong answers”. However, I later questioned if my efforts to ensure participants felt comfortable in the interviews inadvertently limited the depth to which I probed their responses. This reflects broader concerns in the literature, clinician-researchers may avoid querying participants with similar professional identities out of professional solidarity or fear of provoking defensiveness (Hay-Smith et al., 2016).

These reflexive tensions led me to question the impact of my clinical identity on the data generated. Participants may have tailored their responses to align with what they perceived to be normative professional beliefs. Conversely, my insider status may have represented an ability to glean rich, practice-relevant data (Freeman-Sanderson et al.,

2024). An asset highly valuable to the focus of the study; to understand how CBT is applied within real-world clinical practice.

During analysis, I noticed a strong urge to highlight themes relating to systemic pressures and the emotional burden of therapeutic work. These themes, although of high clinical importance, often fell outside of the research aims. I had to actively re-anchor myself to the research questions, to prevent the analysis deviating due to my empathetic alignment with participants. I discussed this challenge with my supervisor, who reminded me that acknowledging these dynamics as a part of the analytic process is vital, rather than attempting to ignore them completely. As Braun and Clarke (2022) suggest in their RTA guidance, transparency about positionality is not a threat to validity but instead a means of enhancing credibility.

In summary, my dual identity as a clinician and researcher played a formative role throughout the project. It offered increased insight into participants' experiences, however introduced interpretative vulnerabilities. Maintaining reflexive awareness through keeping a journal, accessing supervision, and seeking out the literature base to help make sense of my experience was essential to navigate these dynamics and uphold the integrity of the research process.

My Alignment with Theoretical and Clinical Models

My theoretical alignment with relational therapy models, such as Cognitive Analytic Therapy (Ryle, 1990) and Schema Mode Therapy (Young et al., 2003), likely influenced my engagement with the project. Both papers demonstrated a strong emphasis on the therapeutic relationship, a focus which may reflect my own implicit working model in a therapy role. As reflexivity is essential to credibility and transparency in qualitative research

(Finlay, 2002), I made my supervisor aware of these preferences at the project's outset. This aimed to ensure these potential biases could be actively discussed and reflected upon.

This became especially relevant during the review synthesis process. While presenting my emerging constructs, my supervisor noted my use of attachment-based language. Specifically, my use of the term "secure base" (Ainsworth et al., 1978) to describe service users' depictions of losing the therapeutic relationship. This prompted reflection on how my therapeutic preferences may have influenced my interpretations. Returning to the first and second order constructs of the included papers helped to ensure that participant meanings were not overshadowed by theory-driven language. This process aligned with meta-ethnography literature which emphasises the importance of prioritising participants original voices, while being mindful of the influence of both primary and secondary authors (Toye et al., 2014).

As expressed in the *Background Influences of the Project* subsection of this critical appraisal, the research team has a shared interest in PCT (Powers et al., 1960) and MOL (Carey., 2006). When applied to mental health services, these approaches recommend ceding control to service users, empowering them to resolve internal conflicts and regain control over their own experiences (Griffiths, 2023).

Themes of control and conflict, consistent with PCT, emerged within both papers. In the review paper, service users described positive experiences when they felt the ending aligned with their wishes, and conversely experiencing distress when they felt a lack of control over the ending process. Recognising this overlap, I returned to the included papers to ensure these themes were derived from the data, rather than resulting from my alignment with PCT. Second order constructs of "Therapy as a threat and a loss of control"

(Wilson et al., 2004), “Initiating and establishing ending as a negotiable process” (Råbu et al., 2013), and “Client and therapist disagreed on termination” (Oliviera et al., 2017) appeared to support the interpretation that control was perceived as a salient issue within ending processes. To check for potential bias, I shared my interpretations with a third-party colleague, making my interest in PCT transparent. After reviewing the datasets, the colleague agreed that control was a strong cross-cutting theme, reinforcing confidence in the credibility of the synthesis.

Within the empirical paper, many therapists articulated their implicit working models involved navigating beliefs, or practices, that were at times in tension with each other. This closely aligns with the concept of conflicts within PCT, where competing internal reference points can impede a person’s ability to maintain control or achieve higher-order goals. For instance, several participants described striving to foster client agency whilst also feeling bound by CBT protocols involving directive skills teaching. Given my interest in PCT, I was mindful of the potential for bias in how I interpreted these accounts. To address this, I critically reviewed the prevalence of conflict across the dataset, which confirmed that these experiences were clearly expressed by many participants. I considered conflict in relation to the existing research base which demonstrates that therapists continually adapt their practice in response to the complex and unpredictable nature of real-work therapeutic work (Trasmundi et al., 2023; Råbu & Binder, 2024). These studies emphasised that nuanced decision-making is common, further supporting the credibility of the presence of conflict. However, reflecting on my language choices, I recognised that my use of the term conflict may have reinforced my own theoretical lens. Alternative terms, such as tension or incongruence, may have conveyed similar meanings. This has made me more aware of how

theoretical interests can shape language use and stresses the importance of ongoing reflexivity.

Maintaining a Critical Realistic Perspective

At times, I found the analysis process of the research project challenging. As I began to develop themes, I experienced feelings of uncertainty, questioning whether my interpretations had addressed the research questions and captured the depth of participants' data. I raised these concerns in supervision, where I was encouraged to reflect on the roots of these feelings. Through this conversation, I recognised that I had spent considerable time engaging in literature which positions CBT as an evidence-based therapy, and theorises biological change mechanisms (e.g., Jung & Han, 2024; Kambeitz-Llankovic et al., 2022; Hollon et al., 2006). Sub-consciously this literature had shifted my expectations of the data. I found myself searching for clear, objective mechanisms of change, rather than focusing on how therapists make sense of their work.

This realisation prompted me to return to the critical realist position underpinning the study. Critical realism assumes that while there may be real psychotherapy mechanisms at play, we understand them only in part and this is mediated by experience, context, and interpretation (Bhaskar, 2008). Realigning with this allowed me to recentre my approach, reaffirming that the aim was not to uncover definitive truths about how CBT creates change at a functional or biological level, but to explore therapists' subjective beliefs and how these shape their clinical practice. This allowed me to engage with the data with increased confidence, prioritising participants' meaning making over mechanistic explanations.

The interviews yielded rich accounts, and I encountered the common RTA challenge of multiple valid paths for theme development. Braun and Clarke. (2022) address the

temptation to continuously analyse data in efforts to seek even deeper insight, and I found myself falling into this trap. Reflecting on their advice, I recognised that I had reached a point in which a deep, nuanced understanding had been established. I sought feedback from a third-party colleague, providing them with emerging theme descriptions, subthemes, and data extracts. They proposed an alternative thematic structure, grouping content by the type of CBT intervention described. While an understandable suggestion, I felt this risked losing nuance within therapists' accounts such as their beliefs about selling the model, holding hope for clients, and therapeutic goals of fostering accountability. Though our discussion, the colleague agreed that the themes I had developed better captured the depth of participant accounts. This reaffirmed my confidence in the thematic structures. It also illuminated how tempting it can be to try and seek clear answers about how interventions work, rather than focusing on the beliefs of therapists delivering it. I considered that my own discomfort with the analysis process may reflect a broader unease with the complexities of psychotherapy, and trying to make sense of what I personally believe I do in the therapy space to create change. Embracing a critical realistic perspective helped me to navigate this discomfort and remain focused on the interpretative and meaning making aims of the study.

Limitations

A limitation of the research study is its reliance on therapists' generalised accounts of their clinical practice. Maintaining the confidentiality of clients, participants were not asked to reflect on specific case examples and instead encouraged to speak abstractly about their beliefs concerning CBT for depression. Recall bias may have been present, in which participants' responses were filtered through training or theoretical frameworks, personal values, and their perceptions of normative professional beliefs. As their responses were not

anchored in a real clinical encounter, their narratives may have been hypothetical rather than a true reflection of their clinical practice.

A limitation of the empirical paper was the inability to collect accurate data on therapists' length of qualified practice, as most were unsure of the exact duration. This restricted analysis of potential links between years of experience, beliefs about change mechanisms, and clinical practice such as adherence to protocols. In future studies, this could be addressed by offering time brackets, such as 0-5 years' qualified experience; 6-10 years' qualified experience, allowing therapists to respond without needing precise figures.

Whilst the meta-ethnography approach of the systematic literature review allowed for higher-order conceptual understanding of therapy endings across a diverse range of contexts, the approach has limitations. Synthesis of varying therapeutic contexts, such as multiple therapeutic modalities, alongside time-limited and open-ended therapy, may unintentionally reduce important distinctions of setting-specific factors. Nuance connected to these factors may have been diluted or lost, as the synthesis sought to identify overarching understanding. This may limit the practical application of the findings to particular clinical settings.

Both papers may lack attention to intersectionality and consideration of how social identities such as race, class, disability, and diagnosis shape individuals' therapy experiences. Whilst the papers offer insight into therapy processes and endings, they assume clients' experiences to be largely universal. The potential impact of systemic inequalities or marginalisation on therapy engagement or ending experiences is not considered. For example, depression frequently coincides with other mental health diagnoses (Panagioti et al., 2012). The research paper cannot identify if presence of

comorbidity would alter what therapists perceived their internal goals of their approach to be. Additionally, those identifying as sexual minorities are at greater risk of dropping out of therapy (Anderson et al., 2019). The review does not assist in identifying how a marginalised identity may contribute to therapeutic engagement or ending experience. The papers may risk overlooking the roles that power and marginalisation may play in psychotherapy experiences.

Future Research and Implications for my Clinical Practice

Relating the Project Findings to Avenues for Future Research

Whilst not an explicit focus of either the systematic review or research study, both outcomes contribute meaningfully to the expanding literature base on the potential for harm in psychotherapy. In the review, a sub-theme emerged around service users' experience of ending therapy following unsatisfactory experiences. Whilst participants who ended unsatisfactory therapy characterised it as an empowering decision, their accounts expressed the distress they experienced during the therapy. This was particularly prevalent when they had perceived their therapist as unresponsive or invalidating. Within the empirical paper, therapists raised concerns about the unintended consequences of cognitive formulations. They questioned if drawing links between clients' current difficulties and their past adverse experiences caused distress and retrospectively reframed once positively perceived relationships as damaging.

These findings align with a growing body of research highlighting that psychotherapy can produce unintended negative outcomes. Schermuly-Haupt et al. (2018) reported that approximately 9% of individuals, who experience CBT, attribute symptom deterioration to their therapy experience. Recognition of the potential for these outcomes has resulted in

the development of validated tools to assess for therapeutic harm, such as The Positive and Negative Effects of Psychotherapy Scale (PANEPS; Moritz et al., 2019) and the Negative Effects Questionnaire (NEQ; Rozental et al., 2016). Themes within the systematic review synthesis may map onto specific items of these tools, such as perceived dependency on the therapist, therapeutic ineffectiveness, difficulties within the therapeutic relationship, and transgressive therapist behaviours. Notably, therapists' concerns in the empirical study regarding the potential for formulations to cause distress, or ruptures in personal relationships, may closely represent the NEQ's item, "negative developments and stress in daily life".

Given these insights, future research would benefit from examining therapists' awareness of adverse therapy effects, and how this informs their clinical decision making. For example, how do therapists weigh the risks of distress resulting from formulations against the potential for therapeutic benefit? Additionally, therapists in the empirical paper emphasised the importance of conveying a belief that CBT and their therapeutic approach can benefit the client. Research could explore whether these beliefs impact how information about the therapy's efficacy is communicated to clients. Rozental et al. (2019) found that 8.2% of clients report increased feelings of hopelessness after therapy, and 5% describe developing feelings of dependency on the therapy, highlighting the importance of preparing clients for both positive and negative outcomes.

In light of this, further studies could explore the extent to which informed consent is provided to clients regarding psychological therapies offered to them. They could explore what information clients receive, such as efficacy information, common side effects, and expected progress trajectories. This could have the potential to enhance transparency and

empower clients to come to informed decisions when they are considering engaging in therapy.

Impact on my Future Clinical Practice

Engaging with this research project has significantly impacted my developing professional identity. Both the empirical study and literature review have deepened my understanding of psychotherapy, and my position as a therapist. They have reframed my perspective, highlighting psychotherapy as a process of collaborative meaning-making where relational dynamics and the client's perspective of the therapist are central. This insight has reinforced the importance of attuning to clients' shifting experiences, values, and sense of agency.

My understanding of power within the therapeutic relationship has grown significantly. While I previously considered myself as having a good awareness of these dynamics, this project illuminated the subtle ways in which therapists can influence the meaning making journeys of clients during therapy. It has prompted me to critically reflect on how practices presented as collaborative can still place therapists in positions of authority. In response, I have become more committed to transparency with clients, presenting psychotherapy as potentially helpful but not unanimously so. I offer formulations as hypothesis rather than definitive truths. I hope this stance allows clients to take what is meaningful to them from the work we complete together and respects their autonomy and perspectives. The project has deepened my appreciation for the relationships I build with clients as potential sources of healing and development. It has helped me to grow my comfort with uncertainty regarding therapy's outcomes and has supported my confidence to share this with clients. While I cannot guarantee for clients that therapy will be effective, I

can offer a safe and genuine relationship to them of which we can explore their experiences together.

I believe I am more attentive to how endings are experienced by clients from my engagement in the project. Endings are experienced positively when clients feel they have control and choice. Although I may not be able to concede all control, especially when faced with systemic constraints, I can support clients to process endings meaningfully. I aim to provide choice in how endings are approached, utilise tools collaboratively, create space for open reflection on therapeutic progress, respecting clients' perspectives on this.

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Section Four: Ethical Approval

Word count (excluding references): 3439

Olivia Johnson

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

May 2025

Substantial Amendment Form v1.9.3 jan 2025

Substantial Amendment Form v1.9.3 jan 2025 - 1 SA

An investigation into the beliefs therapists have about how CBT for depression works. - Approved

Amendment Information

Please note:

This form is for making substantial amendments to applications previously approved in REAMS. All "Substantial Amendments" will go through the review process again. Please check the "Amendment Guidance" to see if you can use the "Minor Amendment" form.

Please number which amendment this is:

1

Amendment Summary

Please summarise your changes and the reasons why you are making them. Ensure that you indicate which parts of the form have been altered.

Change to personal details collected from participants:
Inclusion of collecting information on the population participants work with and what therapy qualifications they hold. This change has taken place as it was felt important to have the opportunity to consider participant's responses in line potential differences that applying CBT in varying populations may present and the therapy training they have received i.e., clinical psychologists may apply CBT differently than those who have trained specifically in CBT such as CBT therapists.

Changes in answers on REAMS form as below:
You have indicated that you will collect identifying information from the participants. Please describe all the personal information that you gather for your study which might be used to identify your participants.
- Full name
- Telephone number
- Gender
- Job title
- Years of experience in their role.
[ADDED TEXT- What population participants work with.
- What therapy qualifications they hold.]

Please describe how the data will be collected and stored.
Full name and telephone numbers will be collected from individuals if they respond to advertisements expressing interest in participation in the study. Telephone numbers will be collected to check participants are eligible to participate in the study, and to discuss the participation and consent process.

Gender, job titles, length of time in their roles, [ADDED TEXT population worked with, and therapy qualifications] will be gathered during the interviews, pseudonymised and stored in a separate password protected file from other data generated within the interview.

All participant data will be stored on a password protected Lancaster University laptop, the data will be stored on the Lancaster University approved file system, OneDrive, and will be encrypted. Participants will be provided with unique pseudonym identifiers when they enter the study, this will be used to link participant's personal information to their interview data. Participants consent forms will be stored in a separate location to their interview data on the University OneDrive. The interviews will be recording using the record feature of Microsoft Teams. Immediately following the interview, the MP4 recording will be converted to MP3 using VLC software of the University provided laptop. The MP4 file will be immediately deleted following conversion. Interview data will be uploaded to the OneDrive system after each interview promptly and removed from all other locations. Participant interviews will be provided with a pseudonym, transcribed, and saved onto the OneDrive. Once transcription has taken place, audio recordings will be retained in case these need to be listened to during analysis for check the accuracy of the transcripts. Once data analysis has been completed all audio recordings of interviews will be deleted from the University OneDrive. Consent forms, and pseudonymised personal information and transcripts, will be retained by the university in accordance with research standards for ten years.

Change to inclusion criteria
Inclusion criteria amended to those who work at Step 3 or above within the NHS talking therapies stepped care model or, for those who work outside of the NHS system, those who provide an equal level of intervention. Those outside of the NHS system would be asked the following questions to ascertain that the therapy they deliver would meet the threshold for a Step 3 intervention: is there a longitudinal formulation which is created collaboratively in therapy sessions which guide the intervention, and would depression presentations be of moderate to severe in presentation. Answers of yes to both of these questions would mean that an individual is eligible for the study. This change has been created to increase homogeneity of the sample.

This has been changed on the inclusion criteria section of the research protocol, however there is no option to attach an amended research protocol to a substantial amendment form. I have enquired about this via email but have not received a response. I have altered the participants section of the REAMS form as follows to reflect this:

Please explain the number of participants you intend to include in your study and explain your rationale in detail (eg who will be recruited, how, where from; and expected availability of participants). If your study contains multiple parts eg interviews, focus groups, online questionnaires) please clearly explain the numbers and recruitment details for each of these cohorts (see help text).

Number of participants
The study will aim to recruit 10 participants, this number was generated based on Malterud et al (2015)'s concept of "information power". The concept implies that, in relation to qualitative research, less participants are required when the sample is highly informed about the topic areas of interest. As the study is focusing on therapists who employ CBT, this will maintain homogeneity of the sample. This will ensure 'information power' is not weakened by widening the focus to multiple therapeutic disciplines with alternative hypotheses regarding the aetiology and maintenance of depressive symptoms, and subsequent differences in therapeutic techniques. Additionally, as participants must have one years' experience within their psychological therapist roles, they are likely to hold information salient to the topic areas. The study intends to complete a thematic analysis (Braun & Clarke, 2022) . Researchers implementing this method frequently modify their participant numbers during the process of data analysis, after consideration of the amount of information generated relevant to the research questions (Braun & Clarke, 2016). This approach will be adopted; sample size may be adjusted dependant on the data's ability to answer the research questions. As guided by Braun and Clarke (2022), data saturation will not be an intended outcome of the study, "information power" and information richness will instead be the targets. Ten participants have been stipulated as a minimum number in line with previous doctoral thesis' investigating the beliefs of therapists (Barkan Korcan, 2018). This number will also be feasible in terms of the time constraints involved in the study.

Inclusion Criteria:
• Those whose job role includes delivering psychological therapy.
• Experience of applying formulation-driven CBT to respond to individuals reporting a primary concern of depression.
• A minimum of one years' experience within their therapy roles. This will ensure therapists are basing their beliefs around their experiences within clinical practice alongside the research base.
[ADDED TEXT• Delivers NHS Talking Therapies Step 3 level CBT interventions or equivalent outside of the NHS framework.
Eligibility will be confirmed if a yes is provided for both of the below questions:
• Do you offer longitudinal CBT formulations collaboratively in your practice which inform the intervention for depression?
• Do you work with moderate-severe levels of depression?]
• Living and practicing within the UK, to maintain homogeneity of the sample.
• English speaking.

Recruitment
Recruitment will take a multi-faceted approach. Personal networks will be utilised to advertise the study to services which are known to employ CBT with those reporting depressive symptomology. Advertisement for the study will take place online utilising social media websites and platforms. Posts will be created, with a supplementary poster, and uploaded to social media pages frequented by psychological therapists. These will included Facebook groups such as "UK CBT Psychotherapists" and "Therapists supporting therapists". Posts will detail the study aims, eligibility criteria and provide the researcher's university email address for individuals to express interest in participation. The online register of psychologists held by the BPS, and online register of registered BABCP therapists, may be utilised. The publicly accessible email addresses of those registered may be contacted to advertise the study and invite individuals to take part. This technique was employed by Barkman (2018) to recruit clinical psychologists for participation in a DClin research project.

Change to the interview schedule
Addition of above added questions regarding personal information. Change to the wording of the questions asked in response to interview pilot meeting between the research team. The change in wording was decided upon as it was felt that the old interview schedule may have asked questions in a way which was potentially leading. The new schedule serves to try and allow participants to answer questions about the topic areas in any way they see fit.

Change to study advertisement poster
Reflects the changes to the inclusion criteria.

Will your project require NHS REC approval? (If you are not sure please read the guidance in the information button)

○ Yes ◉ No

Do you need Health Research Authority (HRA) approval? (Please read the guidance in the information button)

○ Yes ◉ No

Have you already obtained, or will you be applying for ethical approval, from another institution outside of Lancaster University? (For example, an external institution such as: another University's Research Ethics Committee, the NHS or an institution abroad (eg an IRB in the USA)? Please select one of the following:

◉ No, I do not need ethical approval from an external institution.
○ Yes, I have already received ethical approval from an external institution.
○ Yes, I will be applying for ethical approval from an external institution after I have received confirmation of ethical approval from my Faculty Research Ethics Committee (FREC) at Lancaster University, if the FREC grants approval.

Is this an amendment to a project previously approved by Lancaster University using the previous "paper-based" system (Pre-Jan 2022)?

○ Yes ◉ No

To note: please do not change your answer to this question, as you are completing the Substantial Amendment form therefore it is apparent that this is an amendment to a previously approved Lancaster University project .

Which Faculty are you in?

Faculty of Health and Medicine

Which department are you in?

Health Research

Are you undertaking this research as/are you filling this form out as:

- ○ Academic/Research Staff
- ○ Non Academic Staff
- ○ Staff Undertaking a Programme of Study
- ◉ PhD or DClinPsy student or MPhil
- ○ Undergraduate, Masters, Master by Research or other taught postgraduate programme

Will your research involve any of the following? (Multiple selections are possible, please see i icon for details)

- ☑ Human Participants
- ☐ Data relating to humans (Secondary/Pre-existing data only)
- ☐ Data collection from online sources such as social media platforms, discussion forums, online chat-rooms
- ☐ Human Tissue
- ☐ None of the above

Project Information

Please confirm/amend the title of this project.

An investigation into the beliefs therapists have about how CBT for depression works.

Estimated Project Start Date 27/10/2024

Amended Start Date - *If the start date hasn't changed please re-enter* 27/10/2024

Is this a funded Project?

- ○ Yes
- ◉ No

Research Site(s) Information

Will you be recruiting participants from research sites outside of Lancaster University? *(E.g. Schools, workplaces, etc; please read the guidance in the information button for more information)*

○ Yes ◉ No

Applicant Details

Are you the named Principal Investigator at Lancaster University?

◉ Yes ○ No

Please check your contact details are correct. You can update these fields via the personal details section located in the top right of the screen. Click on your name and email address in the top right to access "Personal details". For more details on how to do this, please read the guidance in the information button.

First Name

Liv

Surname

Johnson

Department

Doctorate in Clinical Psychology

Faculty

Faculty of Medicine and Health

Email

o.johnson2@lancaster.ac.uk

Please enter a phone number that can be used in order to reach you, should an emergency arise.

07531017456

Supervisor Details

Search for your supervisor's name. *If you cannot find your supervisor in the system please contact rso-systems@lancaster.ac.uk to have them added.*

First Name

James

Surname

Kelly

Department

Health Research

Faculty

Faculty of Health and Medicine

Email

j.a.kelly@lancaster.ac.uk

Do you need to add a second supervisor to sign off on this project?

○ Yes ◉ No

Additional Team Members

Other then those already added, please select which type of team members will be working on this project:

- ☐ I am not working with any other team members.
- ☐ Staff
- ☐ Student
- ☑ External

Please list all external contacts here:

First Name

Robert

Surname

Griffiths

Organisation

Manchester University

Details about the participants

As you are conducting research with Human Participants/Tissue you will need to answer the following questions before your application can be reviewed.

If you have any queries about this please contact your Ethics Officer before proceeding.

What's the minimum number of participants needed for this project?

10

What's the maximum number of expected participants?

12

Do you intend to recruit participants from online sources such as social media platforms, discussion forums, or online chat rooms?

(•) Yes ( ) No

You stated that you will be engaging in recruiting participants from online sources such as social media platforms, discussion forums, or online chat-rooms. Please confirm that this either:

- (●) Is clearly in compliance with the online source(s) published terms and conditions
- ( ) Not clear within the online source(s) published terms and conditions, therefore you have obtained written approval from the platform
- ( ) Neither of the above

Will you get written consent and give a participant information sheet with a written description of your research to all potential participants?

(●) Yes ( ) No ( ) I don't know

Will any participants be asked to take part in the study without their consent or knowledge at the time or will deception of any sort be involved?

( ) Yes (●) No ( ) I don't know

Is your research with any vulnerable groups?

(Vulnerable group as defined by Lancaster University Guidelines)

( ) Yes (●) No ( ) I don't know

Is your research with any adults (aged 18 or older)?

(●) Yes ( ) No

Is your research data collected with completely anonymous adult (aged 18 or older) participants, with no contact details or other uniquely identifying information (e.g. date of birth) being recorded?

( ) Yes (●) No

Is your research with any young people (under 18 years old)?

( ) Yes (●) No ( ) I don't know

Does your research involve discussion of personally sensitive subjects which the participant might not be willing to otherwise talk about in public (e.g. medical conditions)?

( ) Yes (●) No ( ) I don't know

Is there a risk that the nature of the research topic might lead to disclosures from the participant concerning either:

- Their own or others involvement in illegal activities
- Other activities that represent a threat to themselves or others (e.g. sexual activity, drug use, or professional misconduct)?

○ Yes ◉ No ○ I don't know

Does the study involve any of the following:

- Physically intrusive procedures including touching or attaching equipment to participants
- Administration of substances
- Ultrasound or sources of non-ionising radiation (e.g. lasers)
- Sources of ionising radiation, (e.g. X-rays)
- Collection or use of samples of Human Tissue (e.g. Saliva, skin cells, blood etc.)

○ Yes ◉ No ○ I don't know

Details about the relationships with participants

Do you have a current or prior relationship with potential participants? For example, teaching or assessing students or managing or influencing staff (this list is not exhaustive).

○ Yes ◉ No ○ I don't know

If you need written permission from a senior manager in an organisation where research will take place (e.g. school, business) will you gain this in advance of undertaking your research?

○ Yes ○ No ○ I don't know ◉ N/A

Will you be using a gatekeeper to access participants?

◉ Yes ○ No ○ I don't know if I will be using a gatekeeper

The gatekeeper will be in a position of authority or have influence over potential participants (e.g., a teacher or manager). However, I will take the gatekeeper's assurance that they will stay completely impartial and that I will ensure that there is no perceived pressure to participate, and I will explain to participants that their decision on whether to participate or not will have no effect on their treatment or rights (e.g., learning or assessment).

◉ Yes ○ No ○ I don't know

The gatekeeper will be able to tell who has participated (e.g., participants' responses will be made directly to the gatekeeper or if the researcher will inform the gatekeeper of who has participated), but I have assurance that they will not use this knowledge to treat participants differently.

○ Yes ◉ No ○ I don't know

Will participants be subjected to any undue incentives to participate?

○ Yes ◉ No ○ I don't know

Will you ensure that there is no perceived pressure to participate?

◉ Yes ○ No ○ I don't know

Details about participant data

Will you be using video recording or photography as part of your research or publication of results?

◉ Yes ○ No

Will you be using audio recording as part of your research?

◉ Yes ○ No

Will you be using audio recordings in outputs (e.g. giving a presentation in a conference, using it for teaching)?

○ Yes ◉ No

Will you be using portable devices to record participants (e.g. audio, video recorders, mobile phone, etc)?

○ No

◉ Yes, and all portable devices will be encrypted as per the Lancaster University ISS standards, in particular where they are used for recording identifiable data

○ Yes, but these cannot be encrypted because they do not have encryption functionality. Therefore I confirm that any identifiable data (including audio and video recordings of participants) will be deleted from the recording device(s) as quickly as possible (e.g. when it has been transferred to a secure medium, such as a password protected and encrypted laptop or stored in OneDrive) and that the device will be stored securely in the meantime

Will you be using other portable storage devices in particular for identifiable data (e.g. laptop, USB drive, etc)? (Please read the help text)

- (•) No
- ( ) Yes, and they will be encrypted as per the Lancaster University ISS standards in particular where they are used for recording identifiable data

Will anybody external to the research team be transcribing the research data?

( ) Yes (•) No

General Queries

Does the funder or any organisations involved in the research have a vested interest in specific research outcomes that would affect the independence of the research?

( ) Yes (•) No ( ) I don't know

Does any member of the research team, or their families and friends, have any links to the funder or organisations involved in the research?

( ) Yes (•) No ( ) I don't know

Can the research results be freely disseminated?

(•) Yes ( ) No ( ) I don't know

Will you use data from potentially illicit, illegal, or unethical sources (e.g. pornography, related to terrorism, dark web, leaked information)?

( ) Yes (•) No ( ) I don't know

Will you be gathering/working with any special category personal data?

( ) Yes (•) No ( ) I don't know

Are there any other ethical considerations which haven't been covered?

( ) Yes (•) No ( ) I don't know

REC Review Details

Based on the answers you have given so far you will need to answer some additional questions to allow reviewers to assess your application.

It is recommended that you do not proceed until you have completed **all of the previous questions**.

Please confirm that you have finished answering the previous questions and are happy to proceed.

☑ I confirm that I have answered all of the previous questions, and am happy to proceed with the application.

Questions for REC Review

Summarise your research protocol in lay terms (indicative maximum length 150 words).

Note: The summary of the protocol should concisely but clearly tell the Ethics Committee (in simple terms and in a way which would be understandable to a general audience) what you are broadly planning to do in your study. Your study will be reviewed by colleagues from different disciplines who will not be familiar with your specific field of research and it may also be reviewed by the lay members of the Research Ethics Committee; therefore avoid jargon and use simple terms. A helpful format may include a sentence or two about the background/ "problem" the research is addressing, why it is important, followed by a description of the basic design and target population. Think of it as a snapshot of your study.

Many forms of psychotherapy exist, each with differing approaches to intervention. With so many alternative therapeutic approaches available, little is known regarding what therapists beliefs are regarding what goals should be targeted by therapy, and how their specific techniques facilitate achieving these outcomes.

This study intends to explore how therapists believe Cognitive Behavioural Therapy (CBT) works for individuals reporting depression. It aims to find out what therapists believe are the intended outcomes of therapy, how they believe their therapeutic approach targets these outcomes, and how these beliefs impact what they do in their clinical practice. Psychological therapists who use CBT with individuals reporting depression will be invited to a semi-structured interview to investigate these aims. Interview data will be transcribed, and investigated using a technique called thematic analysis. Patterns, relevant to the research questions, will be collected together into themes.

State the Aims and Objectives of the project in Lay persons' language.

This study will explore what beliefs therapists, who use CBT with people who are reporting depression have about the intervention. It will investigate what they believe to be the intended outcomes of therapy and how the intervention helps to achieve them. What impact these beliefs have on therapists practice will be explored. It aims to deepen understanding of therapist's views of how therapy works, how it achieves its intended effects, and what processes they believe they target in their work.

This study intends to explore the following questions:
1) What do psychological therapists who use CBT for depression believe about how the therapy works?
2) What outcomes mean a therapy has worked?
3) What processes lead to these outcomes occurring?
4) How do these beliefs impact on therapists' clinical practice?

Participant Information

Please explain the number of participants you intend to include in your study and explain your rationale in detail (eg who will be recruited, how, where from; and expected availability of participants). If your study contains multiple parts eg interviews, focus groups, online questionnaires) please clearly explain the numbers and recruitment details for each of these cohorts (see help text).

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Inclusion Criteria:
• Those whose job role includes delivering psychological therapy.
• Experience of applying formulation-driven CBT to respond to individuals reporting a primary concern of depression.
• A minimum of one years' experience within their therapy roles. This will ensure therapists are basing their beliefs around their experiences within clinical practice alongside the research base.
[ADDED TEXT• Delivers NHS Talking Therapies Step 3 level CBT interventions or equivalent outside of the NHS framework. Eligibility will be confirmed if a yes is provided for both of the below questions:
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• Do you work with moderate-severe levels of depression?]
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Recruitment will take a multi-faceted approach. Personal networks will be utilised to advertise the study to services which are known to employ CBT with those reporting depressive symptomology. Advertisement for the study will take place online utilising social media websites and platforms. Posts will be created, with a supplementary poster, and uploaded to social media pages frequented by psychological therapists. These will included Facebook groups such as "UK CBT Psychotherapists" and "Therapists supporting therapists". Posts will detail the study aims, eligibility criteria and provide the researcher's university email address for individuals to express interest in participation. The online register of psychologists held by the BPS, and online register of registered BABCP therapists, may be utilised. The publicly accessible email addresses of those registered may be contacted to advertise the study and invite individuals to take part. This technique was employed by Barkman (2018) to recruit clinical psychologists for participation in a DClin research project.

You have indicated that you will collect identifying information from the participants. Please describe all the personal information that you gather for your study which might be used to identify your participants.

- Full name
- Telephone number
- Gender
- Job title
- Years of experience in their role.
[ADDED TEXT- What population participants work with.
- What therapy qualifications they hold.]

Please describe how the data will be collected and stored.

Full name and telephone numbers will be collected from individuals if they respond to advertisements expressing interest in participation in the study. Telephone numbers will be collected to check participants are eligible to participate in the study, and to discuss the participation and consent process.

Gender, job titles, length of time in their roles, [ADDED TEXT population worked with, and therapy qualifications] will be gathered during the interviews, pseudonymised and stored in a separate password protected file from other data generated within the interview.

All participant data will be stored on a password protected Lancaster University laptop, the data will be stored on the Lancaster University approved file system, OneDrive, and will be encrypted. Participants will be provided with unique pseudonym identifiers when they enter the study, this will be used to link participant's personal information to their interview data. Participants consent forms will be stored in a separate location to their interview data on the University OneDrive. The interviews will be recording using the record feature of Microsoft Teams. Immediately following the interview, the MP4 recording will be converted to MP3 using VLC software of the University provided laptop. The MP4 file will be immediately deleted following conversion. Interview data will be uploaded to the OneDrive system after each interview promptly and removed from all other locations. Participant interviews will be provided with a pseudonym, transcribed, and saved onto the OneDrive. Once transcription has taken place, audio recordings will be retained in case these need to be listened to during analysis for check the accuracy of the transcripts. Once data analysis has been completed all audio recordings of interviews will be deleted from the University OneDrive. Consent forms, and pseudonymised personal information and transcripts, will be retained by the university in accordance with research standards for ten years.

Please describe how long the data will be stored and who is responsible for the deletion of the data.

I will delete MP4 recordings of interviews immediately following conversion to MP3 which will happen as soon as possible after the interviews take place. MP3 recordings of the interviews will be deleted immediately following completion of data analysis.

Consent forms and pseudonymised personal information and interview transcripts, will be retained by the university in accordance with research standards for ten years. Lancaster University will hold responsibility for deleting this data.

Participant Data

Explain what you will video or photograph as part of your project, why it is appropriate and how it will be used.

Microsoft Teams will be used to interview participants. The software offers a feature to videorecord the meeting which will be utilised for transcription purposes. The participants will be offered the opportunity to turn their cameras off so that only audio of the interview is recorded.

How will you gain consent for the use of video/photography?

Within the written consent form there is the following agreement "I understand that any interviews will be audio and/or video-recorded and transcribed and that data will be protected on encrypted devices and kept secure."

State your video/photography storage, retention and deletion plans and the reasons why.

VLC media player software will be used to convert the MP4 versions of interviews into MP3 as soon as possible after the interviews take place and the MP4 versions will be deleted. The MP3 recordings will be securely stored on OneDrive, the files will be encrypted. These will be deleted following data analysis, to ensure they are available to check for accuracy during the analysis process. I will be responsible for deleting the files at this point.

What would you do if a participant chose to make use of their GDPR right "of being forgotten" or "right to erasure"? Could you remove their data/video/picture from publication? (please see help text).

As stated video recordings will be immediately converted to MP3 and the video will be deleted. MP3 recordings will be deleted following the data analysis process therefore these will not be retained or published.

Will you take all reasonable steps to protect the anonymity of the participants involved in this project?

(•) Yes ( ) No

Explain what steps you will take to protect anonymity.

Only the research team will have access to data shared during the study. Personal information will not be shared with anyone outside of the team and will be kept confidential.

Unique pseudonyms will be provided to participants at the point of becoming a participant in the study. This will be used to link personal information to interview data which will be stored separately from each other on OneDrive, password protected, and encrypted. Both personal information and interview data will be pseudonymised. Consent forms will be stored separately from interview and personal data as they will not be able to be anonymised, they will be stored on Lancaster University's OneDrive, and password protected.

Direct quotes from may be used in the written documents resulting from the study such as my thesis and publication i.e., in academic journals. These quotes will be pseudonymised and therefore not identifiable.

Additional Information

What are your dissemination plans? E.g publishing in PhD thesis, publishing in academic journal, presenting in a conference (talk or poster).

The data will be disseminated via my DClinPsy thesis. I plan to submit for publication in academic journals such as Clinical Psychology & Psychotherapy and Journal of Clinical Psychology. The findings will be presented at the Lancaster University Doctorate in Clinical Psychology's thesis presentation day. An overview of the findings will be made available for participants via email, regardless of whether the study is published within an academic journal.

Online Sources

You have indicated site users have a reasonable expectation of privacy and therefore you will need to obtain consent to use their data for this project. Please explain how you propose to obtain consent.

Recruitment will include advertisement on social media websites and pages frequented by therapists such as "UK CBT Psychotherapists" and "Therapists supporting therapists". The advertisement will include the university email address on which to contact me to express interest in participation. There will be no expectation of individuals to participate and they will experience the same procedures to obtain consent as those recruited through other means.

Additional Information for REC Review

How long will you retain the research data?

MP4 recordings will be deleted once they have been converted to MP3 immediately after the interview takes place. MP3 recordings will be deleted after data analysis takes place.

Consent forms, pseudonymised personal information and transcriptions, will be retained by the university in accordance with research standards for ten years.

How long and where will you store any personal and/or sensitive data?

Pseudonymised personal information will be stored on the Lancaster University approved file storage system, One Drive. It will be accessed on a Lancaster University provided password protected laptop, and the files will be encrypted. Pseudonyms will be applied to the data generated by the interviews, the personal information generated within the interviews (such as gender, job title) will be stored separately from the data generate through responses to interview questions asked. Both these files will be password protected. The participant's unique pseudonyms will enable researchers to link the personal information to interview transcripts. Pseudonymised personal information will be retained, along with pseudonymised interview transcripts, by Lancaster University for 10 years.

Please explain when and how you will anonymise data and delete any identifiable record?

Data will be pseudonymised rather than anonymised.

Immediately after the interviews take place the Microsoft Teams video recording will be converted to MP3 using VLC software, this will remove the video recording of the participant. The MP3 recording will be retained until the data analysis process has been complete, after which it will be deleted.

Upon entering the study, participants' will be provided with a pseudonym. At the beginning of the interviews, participants will be asked personal information (gender, job title, and length of time in their role). During transcription, participants pseudonyms will be applied to the personal data, it will be extracted, retained, and stored in a separate password protected file to the rest of the data generated in the interview such as participants responses to questions asked which will also be pseudonymised. The pseudonymised personal information will be used during the data analysis process. The pseudonym will be used by the research team to link the personal information to the data generated within the interviews.

Telephone numbers will be deleted after interviews take place. Email addresses of participants will be retained, with consent, until the study is written up in order to be able to share the study outcomes with participants. Email addresses will be deleted after the dissemination process.

Consent forms, pseudonymised personal information and pseudonymised transcriptions, will be retained by the university in accordance with research standards for ten years. Lancaster University will be responsible for deleting this data.

Document Upload

Important Notice about uploaded documents:

When your application has been reviewed if you are asked to make any changes to your uploaded documents please highlight the changes on the updated document(s) using the highlighter so that they are easy to see.

Please confirm that you have read and applied, where appropriate, the guidance on completing the Participant Information Sheet, Consent Form, and other related documents and that you followed the guidance in the help button for a quality check of these documents. For information and guidance, please use the relevant link below:

FST Ethics Webpage

FHM Ethics Webpage

FASS-LUMS Ethics Webpage

REAMS Webpage

☑ I confirm that I have followed the guidance.

In addition to completing this form you must submit all supporting materials.

Please indicate which of the following documents are appropriate for your project:

- ☐ I have no updated documents and confirm that all relevant documents were included in previous submissions.
- ☑ Advertising materials (posters, emails)
- ☑ Research Proposal (DClinPsy)
- ☐ Letters/emails of invitation to participate
- ☑ Consent forms
- ☑ Participant information sheet(s)
- ☑ Interview question guides
- ☐ Focus group scripts
- ☐ Questionnaires, surveys, demographic sheets
- ☐ Workshop guide(s)
- ☑ Debrief sheet(s)
- ☐ Transcription (confidentiality) agreement
- ☐ Other
- ☐ None of the above.

Please upload the documents in the correct sections below:

Please ensure these are the latest version of the documents to prevent the application being returned for corrections you have already made.

Please upload a copy of all of the consent forms that you will be using:

Documents

Type	Document Name	File Name	Version Date	Version	Size
Consent Form	Consent Form V2	Consent Form V2 (3).docx	12/11/2024	2	226.4 KB

Please upload a copy of all of the Participant Information Sheets that you will be using in this study.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Participant Information Sheet	Participant Information Sheet V3 (1)	Participant Information Sheet V3 (1).docx	21/11/2024	3	64.1 KB

Please upload all of the advertising materials relevant for this project:

Documents

Type	Document Name	File Name	Version Date	Version	Size
Advertising materials	Thesis Flyer V3	Thesis Flyer V3.png	12/02/2025	3	648.3 KB

Please upload all of the question interview guides used in this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Interview question guide	Interview Schedule Topic Guide V3	Interview Schedule Topic Guide V3.docx	12/02/2025	3	59.7 KB

Please upload all debrief sheets used for this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Debrief sheet	Debrief Sheet V1	Debrief Sheet V1.docx	07/11/2024	1	55.8 KB

Declarations and Sign off

Please Note

Research Services monitors projects entered into the online system, and may select projects for quality control.

All research at Lancaster university must comply with the LU data storage and governance guidance as well as the General Data Protection Regulation (GDPR) and the UK Data Protection Act 2018. (Data Protection Guidance webpage)

☑ I confirm that I have read and will comply with the LU Data Storage and Governance guidance and that my data use and storage plans comply with the General data Protection Regulation (GDPR) and the UK Data Protection Act 2018.

Have you that you have undertaken a health and safety risk assessment for your project through your departmental process? (Health and Safety Guidance)

☑ I have undertaken a health and safety assesment for your project through my departmental process, and where required will follow the appropriate guidance for the control and management of any foreseeable risks.

When you are satisfied that this application has been completed please click "Request" below to send this application to your supervisor for approval.

Signed: This form was signed by Dr James Kelly (j.a.kelly@lancaster.ac.uk) on 18/02/2025 11:45

Please read the terms and conditions below:

- You have read and will abide by Lancaster University's Code of Practice and will ensure that all staff and students involved in the project will also abide by it.
- If appropriate a confidentiality agreement will be used
- You will complete a data management plan with the Library if appropriate. Guidance from Library.
- You will provide your contact details, as well as those of either your supervisor (for students) or an appropriate person for complaints (such as HoD) to any participants with whom you interact, so they know whom to contact in case of questions or complaints?
- That University policy will be followed for secure storage of identifiable data on all portable devices and if necessary you will seek guidance from ISS
- That you have completed the ISS Information Security training and passed the assessment
- That you will abide by Lancaster University's lone working policy for field work if appropriate
- On behalf of the institution you accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- To the best of your knowledge the information you have provided is correct at the time of submission
- If anything changes in your research project you will submit an amendment

To complete and submit this application please click "Sign" below:

Signed: This form was signed by Miss Liv Johnson (o.johnson2@lancaster.ac.uk) on 18/02/2025 09:48