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# Attitudes towards CBT in Trainee Clinical Psychologists

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### Attitudes towards CBT in Trainee Clinical Psychologists

**Abstract**

*Purpose:* The present service evaluation aims to address how one Doctorate in Clinical Psychology (DClinPsy) programme contributes to the shaping of attitudes of its Trainee Clinical Psychologists (TCPs) towards Cognitive Behavioural Therapy (CBT).

*Methodology:* Twenty-eight TCPs completed an online, mixed-methods questionnaire relating to their attitudes towards CBT, what factors had influenced their attitude, and how competent they felt in applying CBT to clinical practice.

*Findings:* The majority of respondents reported a positive attitude towards CBT. There was a statistically significant positive change at an individual level in TCPs' views of CBT between the point at which they applied for the DClinPsy and the present day. Thematic Analysis of qualitative data identified influential factors on the development of TCP attitudes towards CBT. The vast majority of TCPs reported that they felt competent applying CBT in their clinical practice.

*Research Limitations/Implications:* Overall, the DClinPsy has a positive effect on TCPs' attitudes towards CBT. However, the influence of placements has a more mixed effect on attitudes. A small sample size reduced the reliability of these conclusions. Recommendations for further evaluation have been made.

*Originality/ Value:* This paper evaluates the effect of a DClinPsy programme on TCPs' attitudes towards CBT. The value is that it establishes which components of the course have different effects on trainee attitudes.

*Keywords:* Cognitive Behavioural Therapy, CBT, Trainee Clinical Psychologists, Attitudes

*Paper Type:* Research paper

### Introduction

*Policy Context*

Cognitive Behavioural Therapy (CBT)BT is an "active, directive, time-limited, structured approach" that can be applied to a variety of psychological difficulties and psychiatric diagnoses (Beck et al., 1979, p. 3). CBT should be tailored to the individual, however, it has core underlying principles that apply across cases and presentations. The key theoretical assumption of CBT is that it is not events themselves, but the way an individual perceives and structures those events in their mind that determines their emotional and behavioural response (Beck et al., 1979). CBT uses a plethora of techniques to change cognitions, behaviour, and mood (Beck, 2011).

CBT currently has the strongest evidence base of all psychotherapies and is the most widely studied form of psychotherapy, shown to be efficacious in treating a variety of psychological difficulties (David et al., 2018; Hofmann et al., 2012). Randomised controlled trials have shown large effect sizes of CBT in comparison to placebo treatment or treatment as usual (Carpenter et al., 2018; Watts et al., 2015), and CBT also compares favourably to alternative psychological models, such as psychodynamic psychotherapy (Tolin, 2010).

However, there is a growing critique of CBT in relation to both its use in clinical practice and the quality of research that supports it (Dalal, 2019; Smail, 2005). A common critique of CBT is that it relies heavily on Western conceptualisations of distress which often involves negative thoughts about the self mselves and the world, a less common phenomenon among other cultural groups (Moloney & Kelly, 2004). Critiques have also been made regarding the way CBT is delivered; for example, CBT is said to be frequently delivered by recent psychology graduates with minimal experience working within mental health services (Binnie & Spada, 2018). It is worth noting that critiques come from multiple sources; academics (Wheelahan, 2009), therapy practitioners (Dalal, 2019), and, most importantly, from recipients of the treatment (Wood et al., 2016).

There is evidence that, despite its reported effectiveness, CBT is under-utilised in clinical practice (Parker & Waller, 2017) for a variety of reasons including: . This is said to be for several reasons; limited knowledge of practitioners (Becker et al., 2004), clinician anxiety (Deacon et al., 2013), and practitioners' negative attitudes towards CBT (Parker & Waller, 2017).

It is a British Psychological Society (BPS) standard that DClinPsy training courses produce Clinical Psychologists who are competentthat have the competence to deliver psychological therapies. Specifically, trainees must demonstrate competence in CBT and one other model (BPS, 2017).

*Local context and impetus for evaluation*

Anecdotal concerns regarding trainees' resistance to undertaking CBT have been raised by DClinPsy staff at Course Training Committee meetings. These meetings are held biannually and oversee the running of the DClinPsy, ensuring that its strategic aims are met. The concerns had been escalated from the Supervisors' Subcommittee (*Name of course redacted* Doctorate in Clinical Psychology, 2019). Staff suggested that a service evaluation be undertaken to establish empirically whether concerns about CBT are prevalent amongst TCPs, and how the course influences trainees' attitudes towards CBT.

*Aims*

The overarching aim of the service evaluation is to begin to establish how effective a DClinPsy programme is at delivering the national BPS guidance for training clinical psychologists related to CBT. The specific aims of this service evaluation are to ascertain:

- What are the attitudes of TCPs towards CBT?
- Do these attitudes change throughout the DClinPsy?
- What factors contribute to the shaping of these attitudes?
- Which components of the DClinPsy have the greatest influence on TCPs' attitudes towards CBT?
- How competent do TCPs perceive themselves to be in using CBT in their clinical practice?

**Methodology**

*Participants and procedure*

Forty-eight trainees currently enrolled on the DClinPsy were invited by email to participate in a questionnaire on attitudes towards CBT, using the online survey platform *Jisc*. Participants were briefed about the evaluation and its aims in the email. No demographic

data or personally identifiable information was asked of participants;, however, they were reminded that if they gave large amounts of detail in their responses they may be identifiable to the primary researcher, who was a colleague.

*Materials*

The authors developed the mixed methods questionnaire sent to trainees. The questionnaire captured information relating to the aims of the service evaluation. A combination of multiple choice and open-answer questions was used.

*Analysis*

Quantitative analysis was performed using 'IBM SPSS Statistics 25'. The data did not meet the assumptions for parametric tests and were therefore analysed using the non-parametric Wilcoxon Signed-Rank and Kruskal-Wallis H tests. Descriptive statistics were also used.

Qualitative analysis consisted of inductive thematic analysis (TA) using Braun & Clarke's model (2006). TA is a descriptive approach that identifies, analyses and reports patterns within data (Braun & Clarke, 2006; Vaismoradi et al., 2013). Content analysis was considered as an alternative approach, which uses coding and categorising to determine trends in words used (Hsieh & Shannon, 2005; Pope, 2006). Although both approaches involve breaking down large amounts of qualitative data into smaller units, content analysis allows for subsequent quantitative analysis (Morgan, 1993), whereas TA provides a solely-qualitative, nuanced and= descriptive account of the findings (Vaismoradi et al., 2013). TA was chosen over content analysis to retain maximum detail from the primary data. There were enough participants to carry out TA as 10-50 participants are recommended for TAs of participant-generated text (Braun & Clarke, 2013).

**Results**

Twenty eight responses were received, approximately half (53%) of the total population invited to take part. This response rate is similar to other studies surveying TCPs (Brooks et al., 2002; Kuyken et al., 2003; Palomo et al., 2010).

Ten respondents were in the first year of training (36%), 13 were in the second year (46%), and five were in the third year (18%).

Results have been organised to answer each service evaluation aim in turn.

*Aim 1: What are the attitudes of TCPs towards CBT?*

Trainees were asked to respond to the following question "Although we make clinical decisions about what therapeutic approach to use on a client-by-client basis, how would you describe your overall attitude towards CBT in clinical practice, in comparison to (an)other psychological model(s)?" Responses are recorded in Table 1.

Table 1: Trainees' current and previous attitudes towards CBT.

[Insert Table 1]

Non-specific midpoints of a Likert scale can be interpreted differently by individual participants, so two 'neutral' options were given to differentiate between common interpretations of the midpoint (Baka et al., 2012). The option of declaring *ambivalence* towards CBT and a *lack of preference* were differentiated in order to capture conflicted views (seeing both positive and negative aspects of CBT).

Looking solely at respondents' current attitudes towards CBT, when aggregating and comparing between positive, neutral, and negative responses, a positive attitude towards CBT is expressed most commonly, with 57.2% reporting a positive view, 28.5% reporting a 'neutral' view, and 14.3% reporting a view that they currently prefer (an)other model(s).

*Aim 2: Do these attitudes change throughout the DClinPsy?*

Participant ratings on what their attitude would have been to CBT when applying for the DClinPsy (see Table 1) were compared to their current ratings. The 'no preference for any psychological model' and 'ambivalent towards CBT' options were aggregated into a 'no clear preference' option for the purpose of this comparison. The data was treated as dependent data and analysed using a Wilcoxon test as both sets of data were not normally distributed (as confirmed by a Shapiro-Wilk test where p<.05).

A Wilcoxon signed-rank test indicated that current ratings regarding attitude towards CBT (Mdn= 2 ['somewhat prefer CBT to other psychological models']) were statistically significantly higher, with a small effect size, than attitudes towards CBT when applying for the course (Mdn= 3 ['no clear preference']), *T*= 84, *p* =.04*, r*= -.27. Therefore, trainees showed an increased preference for CBT once on the course compared to when they applied.

Current attitudes to CBT were also compared between year groups to assess any cohort differences. A Kruskal-Wallis test was used and no significant difference between attitudes towards CBT across the three year groups was found, *H*(2)= 3.00, *p*=.22.

*Aim 3: What factors contribute to the shaping of these attitudes?*

Trainees were asked "What factors do you think have shaped your current view of CBT?" A TA was undertaken on the responses, resulting in the development of four themes, three of which were divided into subthemes. Gender-neutral pseudonyms were attributed to participants so multiple quotes from the same individual could be recognised.

### Learning by Doing

The participants' experience of CBT applied clinically was frequently mentioned as a factor that shaped their view of CBT. Four participants discussed the application of CBT in general terms. One participant did not state whether this had a positive or negative effect on their view, but three of them stated that it had a positive influence on their attitude:

*"I have seen good outcomes with clients".* (Sam, 1st year)

Despite some general comments like Sam's, more respondents provided further detail relating to the context of the application of CBT. These responses have been grouped into the following subthemes.

### *On placement*

Eleven respondents stated that the application of CBT on placement influenced their view of the model. The majority of respondents said placements positively affected their view of CBT, but some reported a negative or mixed effect. Comments that represented a positive development in their view of CBT included:

*"My experiences in an EIP service where I felt I got a better grasp of how specifically CBT can be helpful and how to increase effectiveness".* (Alex, 3rd year)

For some participants, placement experience led to the view that CBT was sometimes not effective in practice:

*"Whilst a large number of people I have worked with have found CBT to be helpful for them, there are others that have not."* (Bailey, 2nd year)

No participants stated a completely negative effect of applying CBT on placement in shaping their attitude towards CBT. However, some individuals found that placements did not provide sufficient opportunity to utilise CBT:

*"In the particular service I am on placement in, many of the clients allocated to my caseload are not suitable for CBT I am able to provide (often because they require specific trauma focused work which is not given to first year trainees in this placement). This leaves a very small pool of clients whom I am able to use a CBT framework…"* (Hayden, 1st year)

Responses included discussion of their own application of CBT in their clinical work, as previously discussed, but one individual also mentioned the influence of the use of CBT by others in the service:

*"Exposure to CBT on placement, this being the model most commonly used by placement supervisors"* (Taylor, 2nd year)

One trainee also mentioned the influence of having a supervisor who struggled to support the practical application of CBT on placement:

*"Lack of confidence of supervisor in being able to support CBT knowledge development"* (Jordan, 3rd year)

### *Before the course*

Five individuals discussed the positive effect of practical experience they had using CBT before the DClinPsy started:

*"In my previous roles as a Support Worker and an Assistant Psych I developed an understanding of some CBT theory, skills and techniques and felt, when I started the course, that I had a semi-decent understanding and appreciation for the theory and effectiveness of the approach"* (Micki, 1st year)

Micki's comment highlights the influence of attitudes formed before trainees commenced the DClinPsy on their current view.

### *To oneself*

One individual mentioned their own personal experience of applying CBT techniques:

*"I personally have a very high opinion of behavioural techniques such as exposure- I see them work in my own personal life on a daily basis."* (Leslie, 2nd year)

In summary, responses given relating to this theme indicated that participants' view of CBT was largely positively affected by their practical application of CBT across multiple contexts. Most quotes pertaining to this theme were explicitly stating this effect, and little interpretation about the underlying meaning of the data was undertaken.

### *Processes of Professional Development*

This theme refers to aspects of the individuals' development as Clinical Psychologists and has been broken down into four subthemes:

### *Learning about CBT*

Nine participants spoke of the influence of teaching on the DClinPsy positively affecting their view of CBT:

*"I think from the beginning of the course my impression of CBT gradually improved as I enjoyed the teaching. For me, I had little therapy experience, so CBT was the therapy I knew most about going into my first placement"* (Leslie, 2nd year)

*"Before starting the course I had a very negative view of CBT. This view changed through teaching, role plays and subsequent use of CBT during placement."* (Storm, 1st year)

Storm's comment indicates a direct influence of their learning about CBT on the development of positive attitudes towards CBT, in combination with the practical application of CBT. The quote also highlights that this effect was noted even by people with an initially very negative view of CBT.

### *Using a person-centred approach*

Ten respondents mentioned the importance of choosing a therapeutic model based on the individual they are working with:

*"I'm happy to use CBT but my therapeutic approach is driven by the individual, their goals for therapy, and their perception of the problem"* (Bailey, 2nd year)

Some people also referred to the importance of integration of therapeutic models:

*"However, not being too constrained by the CBT model has encouraged me to use it alongside consideration of other models such as CAT, systemic, psychodynamic principles"* (Alex, 3rd year)

Alex's comment implies that many trainees are flexible in their therapeutic approach. The reasoning behind this flexibility was not clear, e.g. whether it was to provide tailored client care or to fulfil a desire to move away from CBT 'constraints'. However, integration is often used to meet individual clients' needs, so the quote has been included within this subtheme.

### *Reflecting on "my view of the world"*

Two respondents reflected on CBT not fitting with their personal understanding of distress:

*"Whilst personally CBT may not be that aligned to my view of distress or the world, I think I feel most competent in this therapeutic model"* (Morgan, 2nd year)

Morgan implies some maintained appreciation for CBT, despite these observations. Morgan holds two disparate views on CBT simultaneously, and the quote suggests that competence in the model and a personal view of the model can be discrete.

### *Developing confidence in using CBT*

Four individuals discussed confidence or competence in CBT influencing their attitude:

*"I do not have as much knowledge and have not had much training on other models. Therefore I am more confident in using CBT and have a preference towards using it in clinical practice"* (Paris, 1st year)

Paris sequentially linked the level of exposure to CBT; confidence in it; and preference for using it.

Within this theme, a range of aspects of professional development were linked to participants' view of CBT. Most quotes pertaining to the theme were explicitly stating these effects, however, some interpretation about the underlying meaning of the data was applied, e.g. around the use of integration of psychological models to provide person-centred care.

### The Approach Itself

This theme has been broken down into two subthemes to encompass both the overarching evidence base for CBT theory but also specific features of the model:

### Evidence Base

Seven trainees cited the evidence base for CBT specifically as a factor that influences their attitudes towards it. Despite acknowledging the strength of the evidence base for CBT, three individuals also spoke critically of the evidence base:

> *"Whilst CBT has the "best" current evidence base, the idea of what evidence constitutes as valid and how we develop evidence is constructed and therefore only promotes one view"* (Jordan, 3rd year)

Jordan's comment evidences that some trainees have concerns about the manner in which evidence that promotes the use of CBT is developed and considered.

### Specific features of CBT

Participants spoke about particular features of CBT that influenced their attitude:

*"Inherent aspects of CBT as a model"* (Jordan, 3rd year)

Eleven respondents went into further detail and cited specific features of CBT that influenced their attitude towards the model. Features that were cited as having a positive influence on their view were: provision of structure to sessions, simplicity of the framework to make therapy accessible to clients, transdiagnostic usability, focus on symptom reduction, and clear aims of CBT. There was both overlap and difference between the aforementioned features and those that were cited as having a negative effect on their view of CBT. Factors cited as having a negative effect on attitudes were: rigidity of CBT, intrapsychic focus, power imbalance, focus on techniques rather than the therapeutic relationship, assumption of cognitive primacy, simplicity, challenges in formulating multiple problems, strict agendas, and the approach that there is a right or wrong way to think.

Structure and simplicity were cited as both strengths and weaknesses of the model by different participants. An interpretation of this may be that different personal preferences influence whether features are seen either positively or negatively.

Participants spoke explicitly about the effect of features of CBT on their views so no interpretation about any underlying meaning of the data was required.

### Interpersonal Influences

Others' attitudes towards CBT were also cited as influencing trainees' own attitudes formation. These influential people included clients, placement supervisors, and staff from the DClinPsy programme:

> *"I have met some people who feel they have had CBT before and are keen not to repeat that, which I have found less so with other psychological models…"* (Jerry, 2nd year)

Jerry has found negative attitudes towards CBT in clients to be more common than negative attitudes towards other models. Preferences for other models were also cited to be expressed by supervisors on placement:

> *"I think some of this negative influence around cognitive aspects of CBT has come from supervisors on placement preferring 3rd wave approaches"* (Leslie, 2nd year)

However, some participants discussed supervisors' attitudes more generally:

> *"Other supervisors negative attitude towards CBT"* (Jordan, 3rd year)

Contrasting views on CBT among course staff was also discussed by one individual, and cited as an influencing factor on maintaining an ambivalent attitude towards the model:

> *"I chose ambivalence because I have contradictory feelings toward CBT and I think the teaching on the course has probably shaped this. Some of the tutors are very passionate about CBT and others have been more critical and I see the validity of both arguments. I haven't quite reconciled my own view on it yet!"* (Rory,2nd year)

Trainees cited the effect of multiple people on their view of CBT, highlighting the role of interpersonal influence on attitude formation. The comments pertaining to this theme explicitly stated the effect of the view of others, and little interpretation about the underlying meaning of the data was applied.

*Aim 4: Which components of the DClinPsy have the greatest influence on TCPs' attitudes towards CBT?*

Trainees were asked to rate the effect of individual components of the course on their attitudes towards CBT. The results are presented in Table 2 below.

Table 2: Effects of teaching, placements and research on attitudes towards CBT

[Insert Table 2]

Teaching had a positive effect on trainee attitudes towards CBT, apart from two trainees who rated it as having no effect. ~~Of those two responses, one individual stated they had no preference for a particular psychological model, both when applying for the course and currently, but that placements had somewhat negatively affected their attitude towards CBT and research components had somewhat positively affected their attitude towards CBT; the other stated that they had previously somewhat preferred other psychological models to CBT and now somewhat preferred CBT to other psychological models, but rated that placements had strongly positively affected their attitude towards CBT.~~

The effect of placements on trainee attitudes towards CBT was mixed, with a slight majority of people reporting a positive effect on their attitudes, but a substantial minority for whom placements had somewhat negatively affected their view of CBT. T~~Of the t~~wo participants ~~who~~ said placements had no effect on their attitude towards CBT~~, one rated that they had somewhat preferred CBT upon applying to the course and this rating remained; the other rated that they had previously somewhat preferred other psychological models and now had no preference~~.

Research components of the course seem to have a slight positive effect on some individual's view of CBT, but it would be logical to assume that this is likely to only have an effect if undertaking CBT-related research.

*Aim 5: How competent do TCPs perceive themselves to be in using CBT in their clinical practice?*

Trainees were asked "How competent do you think you are in applying CBT to clinical practice? Please also consider feedback from assignments and placements in answering this question." The responses have been broken down by year group in Table 3.

Table 3: Self-reported competence applying CBT to clinical practice

[Insert Table 3]

A Kruskal-Wallis Test was conducted to examine the differences in self-reported competence applying CBT to clinical practice of TCPs across three year groups. No statistically significant differences were found between the three year groups, $H(2) = 5.92$, $p=.05$.

The vast majority of trainees reported themselves as 'somewhat competent' or 'very competent' in applying CBT to clinical practice, with only one second year trainee stating that they felt 'somewhat incompetent' in this skill.

*Considerations throughout analysis*

In light of the researcher's link to the DClinPsy programme, precautions were taken to reduce bias. Under such circumstances in qualitative research where a degree of interpretation is applied to the data, it is advisable for the researcher to reflect on their own personal position in relation to the data.

*Reflection*

As the first author, I analysed the data for the service evaluation in as neutral a way as was possible by following the guidelines for TA (Braun & Clarke, 2006). I looked for outliers and alternative perspectives in the data, and information was included in the analysis that I both agreed and disagreed with. However, it is important to be transparent about my personal views of CBT. I have an ambivalent attitude towards CBT; I acknowledge its many strengths, such as its evidence base and versatility for effective use across multiple presentations, however, I do not regard it as appropriate for all presenting issues, e.g. those relating to issues rooted in structural inequality and oppression, where I find CBT's largely intrapsychic focus at best irrelevant, and at worst, harmful.

**Discussion**

The evaluation generally yielded results that suggest the DClinPsy programme has a positive effect on trainee attitudes towards CBT with . Tthe academic components of the course steeringed this positive effect most clearly, whileith placement experiencess yieldeding a more mixed result.

The results of the evaluation will be disseminated to key stakeholders, including trainees. Findings will be fed back at the DClinPsy programme's Course Training Committee and Supervisors' Subcommittee. Appropriate action will be taken forward by relevant individuals within the programme's management team. The author will also submit a presentation of the findings to relevant conferences.

The findings contribute a novel exploration of trainee practitioner attitudes towards CBT. This is an important topic to explore as previous research findings suggest that the attitudes of clinicians should be acknowledged when considering why many clinicians may not deliver evidence-based CBT (Parker & Waller, 2017). Therapist allegiance to the model they choose and their belief that the treatment is effective contributes to improved outcomes in therapy (Wampold & Imel, 2015).

*Recommendations*

The effect of placements on trainee attitudes to CBT is mixed and further exploration to establish what aspects of placements results in the difference is warranted. The present evaluation has suggested that the attitudes of others affect trainees' attitudes towards CBT, thus the attitudes of placement supervisors or clients' attitudes could be influential. Alternatively, a variation in the ease or difficulty with which CBT can be applied to the clients may account for the differing experience of trainees, or other influencing factors that have not been identified by the present service evaluation could also contribute. A more detailed evaluation of the effect of placements on attitudes towards CBT involving both trainees and their supervisors would help to identify the factors and processes involved.

It would also be interesting to explore a more concrete evaluation of how often CBT is applied in clinical practice by trainees. Considering the results of the evaluation within the framework of the theory of planned behaviour, where attitude, subjective norms and self-efficacy have been shown to be predictive of behavioural intention (Ajzen, 1985; Farrer et al., 2014), it could be evaluated whether these factors directly relate to the behaviour of trainees applying CBT to clinical practice. Data on models used in therapy by trainees is routinely collected as part of the 'client log' for each placement, so this could be used as a measure of what psychological models are applied in practice. The addition of a measure such as the Revised Cognitive Therapy Scale (Blackburn et al., 2001) to examine objective competence in delivering CBT would strengthen future evaluations. This could be collected as part of a prospective study, where questions pertaining to CBT attitudes are collected at the start of the DClinPsy course and repeated each year.

In terms of recommendations for the programme, module convenors may wish to look in further detail at the responses around specific features of CBT that individuals do not value in order to address any concerns around validity of these critiques in teaching.

The largest course-related negative influence on attitudes towards CBT was found to be experience on placements. This could be discussed and assessed further in supervisor training. Furthermore, attitudes towards CBT and development as a CBT practitioner could become a standing item for discussion at placement reviews. A question could also be included on the placement feedback forms to try and capture the effect of that particular placement on trainee views of CBT.

*Limitations*

Although the response rate was similar to that of other studies recruiting TCPs, 20/48 people approached did not respond. It would be interesting to know the reason that these people did not participate, e.g. disinterest in CBT so were less inclined to complete the survey, as this could suggest influence of a nonresponse bias (Fricker, 2016; Sax et al., 2003) and potential skewing of the results.

The sample size is small due to both a limited response rate and also a small population to recruit from, which reduces the power to detect meaningful differences when

undertaking statistical tests (Biau et al., 2008). The individual-level of statistical analysis is less thorough than it could have been as it is difficult to get a reliable estimate of internal consistency as we do not have data for multiple items, and a test-retest correlation would require data from multiple time points.

The ratings of TCP's attitudes towards CBT from when they applied to the DClinPsy relied on accurate recall. Recall bias may have had an effect and current attitudes can influence recall of past views and behaviours (Ross et al., 1981). Furthermore, the questionnaire relied entirely upon self-report, which reduces the validity of the results and may have elicited socially desirable responding from trainees. Future evaluations undertaken using a questionnaire may benefit from the inclusion of a social desirability scale (van de Mortel, 2008).

Features of CBT were critiqued by participants, who stated that these features influenced their attitudes towards the model. There was little scope in the methodology to evaluate the validity of these critiques, however, this might have been useful in order to assess competence in trainee understanding of CBT.

Despite attempting to maintain neutrality in the analysis of qualitative data, there was no way to completely eliminate bias. Potential for bias was exacerbated by the other researchers involved having a vested interest in the outcome of the service evaluation.

*Conclusions*

The anecdotal concerns regarding trainees' attitudes towards CBT have been shown to have limited empirical support as, although trainees appear to think critically about CBT, most trainees have a positive attitude towards CBT. There was also a statistically significant positive change in attitudes towards CBT from when individuals[2] applied for the course compared with their current view. Many factors contributed to this change, mainly the teaching about CBT and the application of CBT on placements. However, a TA of qualitative responses also highlighted the role of pre-course experience, the alliance of the model with individuals' view of the world, confidence applying the model, and the influence of the views of others. The vast majority of respondents reported that they were competent in applying CBT to their clinical practice. Further evaluation on the effect of placement experience on these attitudes and the extent to which trainees apply CBT in clinical practice is recommended.

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[Table 1]

| Response | When applying for the course Frequency (%) | Current view Frequency (%) |
|---|---|---|
| Strongly prefer(red) CBT to other psychological models | 1 (3.6) | 1 (3.6) |
| Somewhat prefer(red) CBT to other psychological models | 8 (28.6) | 15 (53.6) |
| I am (/was) ambivalent towards CBT in comparison to other psychological models | 7 (25) | 6 (21.4) |
| I have (/had) no preference for a particular psychological model | 4 (14.3) | 2 (7.1) |
| Somewhat prefer(red) other psychological models to CBT | 5 (17.9) | 3 (10.7) |
| Strongly prefer(red) other psychological models to CBT | 3 (10.7) | 1 (3.6) |

[Table 2]

**Response (%)**

| Feature of the course | Strongly positively affected my attitude towards CBT | Somewhat positively affected my attitude towards CBT | No effect on my attitude towards CBT | Somewhat negatively affected my attitude towards CBT | Strongly negatively affected my attitude towards CBT |
|---|---|---|---|---|---|
| **Teaching** | 5 (17.9%) | 21 (75%) | 2 (7.1%) | 0 (0%) | 0 (0%) |
| **Placements** | 4 (14.3%) | 11 (39.3%) | 2 (7.1%) | 11 (39.3%) | 0 (0%) |
| **Research components** | 0 (0%) | 5 (17.9%) | 23 (82.1%) | 0 (0%) | 0 (0%) |

[Table 3]

| Response | First years (% of first year respondents) | Second years (% of second year respondents) | Third years (% of third year respondents) | Total (% of all respondents) |
|---|---|---|---|---|
| Very competent | 1 (10%) | 0 (0%) | 2 (40%) | 3 (10.7%) |
| Somewhat competent | 9 (90%) | 12 (92.31%) | 3 (60%) | 24 (85.7%) |
| Somewhat incompetent | 0 (0%) | 1 (7.69%) | 0 (0%) | 1 (3.6%) |
| Very incompetent | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |