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# A Qualitative Exploration of CBT and Psychodynamic Therapists' Views, Experiences and Perceptions of Integrating Different Therapeutic Modalities into their Private Practice with Adult Clients: Study Protocol

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**Abstract:** *Background:* CBT (Cognitive Behavioural Therapy) and psychodynamic psychotherapy are two most frequently used therapeutic modalities in private and public clinical practice. CBT is currently considered to be a 'gold standard' therapy, culminating in a wide scale training and dissemination of research. More recently, psychodynamic psychotherapy has also amassed increasing systematic research, yielding significant longitudinal outcomes. However, the co-existence of the two therapeutic modalities is not without controversies. Although few authors in psychotherapy suggested that CBT and psychodynamic psychotherapy should be viewed as complementary rather than dichotomous paradigms, little is known about how concepts and techniques from these two different approaches are integrated (if at all) by therapists in private practice. *Objective:* This study protocol paper presents a pilot study, which aims to qualitatively explore how CBT therapists experience and make sense of psychodynamic concepts and vice versa in private practice. Our study is particularly interested in how therapists conceptualise psychodynamic and CBT concepts, and whether they might integrate techniques from different therapeutic modalities in their practice formally or informally. We anticipate that the findings will be relevant for further theoretical and clinical recommendations on how CBT and psychodynamic psychotherapies can be integrated in a pragmatic manner to address idiosyncratic patient treatment needs. *Study Design:* A qualitative survey method will be used to explore how qualified BABCP accredited CBT therapists and BPC accredited psychodynamic practitioners understand, perceive and, potentially, integrate, psychodynamic and CBT principles in private practice. The data collected will be analysed using thematic analysis in order to construct themes

and generate implications for therapeutic integration and practice. Ethical considerations and dissemination plans are examined, with sensitivity towards our target sample.

**Keywords:** Protocol; CBT (Cognitive Behavioural Therapy); Psychodynamic Psychotherapy; therapeutic integration; private clinical practice; application of clinical concepts

## **Introduction**

Currently, CBT (Cognitive Behavioural Therapy) is considered to be a ‘gold standard’ therapy (David et al., 2018), although is not without controversies surrounding this title (Leichsenring & Steinert, 2017). CBT may operate as either an individual or group therapy and seeks to improve clients’ psychological wellbeing by focusing on cognitive distortions (thoughts and attitudes) and core negative beliefs, which in turn promotes emotional regulation and development of adaptive personal coping strategies (Lloyd et al., 2021; McKay et al., 2015). CBT is typically a short-term (10-20 sessions) therapeutic intervention, featuring structured, goal-focused and action-based work with clients. Conversely to psychodynamic (and, more broadly, psychoanalytic) psychotherapy, CBT focuses predominantly (although not always) on the present (current client issues and symptoms) rather than past (early object relations), and involves elements of psychoeducation and behavioural change, through which clients are trained in the cognitive model of emotion via written resources and treatment sessions in order to recognize and challenge negative automatic thoughts through reality-testing.

CBT features a strong emphasis on efficacy research, which seeks to establish cause-and-effect relationships between independent (e.g., intervention) and dependent (e.g., symptoms) variables (Rosqvist, Thomas, Truax, 2011). Consequently, institutions such as the APA (USA) and NICE (UK) endorse CBT theoretical models and mechanisms of change as the most mainstream and efficaciously researched paradigms of human mind and behaviour. This has also culminated in the wide scale training and dissemination of CBT therapists in NHS settings, as well as a growing body of CBT therapists and psychologists in the private sector.

Although psychoanalytic and psychodynamic psychotherapies have recently enjoyed increasing systematic research (see for example, Fonagy et al., 2015), the inherent differences between psychodynamic psychotherapy and CBT have contributed to additional divisions in psychotherapy methodology and outcomes. As a therapeutic intervention, psychoanalysis (and to a large degree, psychodynamic psychotherapy) insists that treatment should take a long time (sessions at least once a week, therapy generally lasting several years), involve unstructured sessions, and develop a (often complex in nature) therapeutic relationship. To a large degree, psychodynamic psychotherapy remains centered around two classic Freudian notions: transference and free association. Transference refers to

feelings, reactions and patterns emerging from client's past relationships, which are re-experienced with the therapist in the here-and-now, while free association is the expression of conscious and unconscious processes during unstructured clinical sessions. These conditions, albeit central to the analysis of early object relations and repressed unconscious material (Gabbard, 2017), may also complicate the implementation of psychoanalytic treatment in public health bodies (e.g., NHS), where time and funding are extremely constrained resources, and private practice, where clients' needs may not always align with the unstructured nature of psychoanalytic treatment or its longevity. Furthermore, psychodynamic psychotherapy has been positioned at the lower end of efficacy research due to unclear causal relationships and lack of generalizability; conditions that have been associated almost exclusively with CBT clinical outcome research (but also criticized as the 'gold standard' criteria for evidence in psychotherapy; see Kaluzeviciute, 2021; Truijens et al., 2019).

Equally, however, the core CBT therapeutic principles, such as structured and goal-directed treatment sessions, psychoeducation, the set amount of sessions, and a cognitive focus on clients' reported problems, may not suit all client needs (Lloyd et al., 2019). This is particularly evident with clients who exhibit long-term mental health issues, including childhood-rooted trauma as well as personality, eating and somatic disorders (Fonagy, 2015; Lunn et al., 2016). Such cases generally warrant the presence of a more complex therapeutic relationship, open-ended treatment, and less structured sessions. Therefore, it seems plausible that there should be a wider dialogue on the use of psychoanalytic and/or psychodynamic and CBT principles by therapists on how some of the key theoretical ideas in both modalities might be integrated to address complex patient needs.

As of recently, authors in psychotherapy suggested that CBT and psychodynamic psychotherapy should be viewed as complementary rather than dichotomous. For example, Haverkamp (2017) proposed theoretical integration between the two modalities on an epistemological level, whereas Garrett & Turkington (2010) suggest that both CBT and psychoanalysis should be used as an integrated approach for treatment of psychosis. However, as of yet, there is little known about how CBT therapists experience and make sense of psychodynamic concepts and vice versa in private practice. Consequently, the current project aims to qualitatively explore how therapists conceptualize psychodynamic and CBT concepts, and whether they might integrate techniques from different therapeutic modalities in their practice formally or informally.

### **Aims and Objectives**

The aim of this qualitative study is to: 1) provide an in-depth, qualitative investigation of how CBT (Cognitive Behavioural Therapy) therapists (BABCP) and psychodynamic therapists (BPC) view their own therapeutic modalities and the relationship between CBT and

psychodynamic theoretical frameworks; 2) explore if and how they integrate CBT and psychodynamic approaches in private practice; 3) understand some of the contemporary issues and barriers common to the integration of different therapeutic modalities in private practice.

## **Method**

### ***Study Design***

A qualitative online survey design will be utilised to explore how qualified BABCP accredited CBT therapists and BPC accredited psychodynamic practitioners understand, perceive and integrate psychodynamic and CBT principles in private practice.

### ***Recruitment and Participants***

Recruitment will take place using self-selected sampling by having participants click on the link to the survey created on Microsoft Forms. Sampling issues have long been debated in qualitative research, with no specific required sample numbers provided (Clarke et al., 2021), however, this study will aim for a minimum of 25 completed responses suitable for analysis.

### ***Eligibility Criteria***

To be eligible for inclusion, participants need to either be BABCP accredited CBT therapists and not hold any other core profession qualification (such as clinical or counselling psychology) or to be psychodynamic therapists (BPC accredited). They will be required to be working in the private practice context in the UK and to have a minimum of two years post qualification experience. Additionally, participants will need to be working with adult clients.

### ***Questionnaire***

Participants will be presented with a series of questions about their clinical experiences and training as well as understanding of integration more broadly in psychotherapy practice.

Acknowledging that some therapists might not have a high degree of knowledge, training or exposure to CBT or psychodynamic therapeutic modalities, we include a broad question about training in or exposure to other therapeutic modalities besides participants' core training through attendance of clinical workshops, engagement with literature, etc. Subsequent questions about CBT and psychodynamic psychotherapies will be led by exemplary definitions of the key concepts pertaining to both therapeutic modalities (*transference* and *unconscious* in psychodynamic psychotherapy, and *core beliefs* and *psychoeducation* in CBT).

Questions about integration include participant experiences, feelings and attitudes toward the usefulness of different treatment techniques and concepts as well as barriers and challenges in integrating different therapeutic frameworks. Finally, we include some questions related to participants' clinical practice, such as whether they worked with clients that could have benefitted from techniques from other therapeutic modalities, and whether they would undertake additional training or consider incorporating other therapeutic concepts depending on individual patient needs. These questions will be presented as semi-structured and open-ended in order to enable detailed and rich participant responses (see Table 1 for qualitative survey schedule).

We anticipate that some of the theoretical concepts or ideas from CBT and psychodynamic therapists will have 'translations' or 'correlate' concepts in both theoretical frameworks (e.g., resistance may be seen as corresponding to cognitive bias). Therefore, the study will analyse survey responses to determine whether these correlates are productive, and whether some (potentially informal) integration between psychoanalytic/psychodynamic and CBT clinical and theoretical frameworks is already occurring in private practice.

Following completion, all responses will be downloaded and qualitatively analysed using thematic analysis (Braun & Clarke, 2006, 2020).

**Table 1. Qualitative Survey Schedule**

*Survey questions*

*Below we will present you with a series of open-ended questions concerning your experiences of our own and different therapeutic modalities. Please take as much time as you need to answer these questions.*

- (1)** Have you had any training in or exposure to other therapeutic modalities besides your own? If yes, please list the modalities and the degree of exposure (e.g., learning through training, attendance of clinical workshops, engagement with literature, etc.).
- (2)** What is your understanding of integration in psychotherapy practice?
- (3)** In your view, can integration of different therapeutic modalities prove to be useful in developing therapeutic relationships with patients?
- (4)** From your experience, are there any barriers or challenges in integrating different therapeutic modalities? Can you give an example from your own practice of any particular challenges or barriers that you may have faced?

**(5)** How do you feel about integrating techniques and principles from CBT and psychodynamic psychotherapies?

**(5a)** If you are a CBT therapist, are there any concepts\* from psychodynamic psychotherapy that you find particularly helpful or problematic?

\*Concept examples: *transference* (occurring when a patient projects feelings and/or reactions experienced with past figures, such as parents, onto the therapist in the here-and-now) and *unconscious* (processes and mechanisms occurring outside of one's conscious awareness that have significant implications for one's personality, behaviours and relationships)

**(5b)** If you are a psychodynamic therapist, are there any concepts\* from CBT that you find particularly helpful or problematic?

\*Concept examples: *core beliefs* (patient's inner beliefs about themselves, others and the world, which determines how they perceive, approach and feel about their life experiences) and *psycho-education* (providing patient with explicit knowledge about therapeutic principles to enable the application of CBT beyond the clinical setting and therapeutic sessions)

**(6)** Can you think of examples from your own training and/or practice in which patients could have benefitted from CBT (if you are psychodynamically trained) or psychodynamic psychotherapy (if you trained in CBT)?

**(7)** What, if anything, can be done to enable practitioners and researchers from different therapeutic modalities to build a common ground and share useful clinical experiences? Can you give some examples?

**(8)** Would you consider undertaking additional training and/or incorporating other therapeutic concepts and techniques into your practice if you felt this was useful for patients?

**(9)** Is there anything that you haven't been asked that you would like to share or comment on?

## **Ethical Considerations**

### **Informed Consent**

A Consent Form will be provided to the participant through Microsoft Forms.

Participants must tick all boxes prior to answering the questionnaires, in order to confirm that they have read and understood the participant information sheet, that they are participating voluntarily, that they understand the withdrawal process and to confirm that they are satisfied with the procedures which are in place to protect their personal information. These procedures include:

- The researchers will not seek more information than what is essential for the study.
- Participants' anonymity will be protected using ID codes.
- Data will be gathered during the study will be used only for the purposes of the study and for any relevant publications that arise from it.
- Data will be stored in password protected databases for no longer than is necessary (7 years) and will be safely destroyed after such time has passed.

### **Debriefing**

The debriefing of participants will consist of providing them with the 'Debrief Form' once questionnaires have been completed. Through the debrief form, participants will be thanked for their participation, the objectives of the study will be re-defined, and participants will be reminded of their right to withdraw from the study, up to one week following survey completion. Participants will also be provided with support contacts, should any of the participants experience any distress, during or after the completion of the questionnaires. The debrief form will also provide a reminder of our ethical and legal requirements in collecting and storing their data so they are fully aware of the guidelines in place.

### **Risk Assessment**

The survey will be disseminated to the accredited CBT and psychodynamic psychotherapists in the UK. Distress is not considered likely to arise from participation in the study. Nevertheless, as the absence of distress can never be guaranteed, all participants will be provided with full details of relevant mental health agencies following their completion of the survey.

### **Remuneration**

No incentive or reward will be offered for taking part in the study.

### **Data Protection**

All consent forms and procedures will be in line with the British Psychological Society (BPS) Code of Human Research Ethics (2014). No personally identifiable information will be collected from participants. All collection and storage of data will be in line with the General Data Protection Regulations (Carey, 2018) and stored securely with the University of Derby server. This will only be available to the researchers.

### **Confidentiality and Deception**

Each participant will be asked to provide a unique identifier, which will consist of the last three letters of their surname and the last three numbers of their mobile number. At the end of the survey, all data will be downloaded onto the secure network of the University of Derby, after which data will be destroyed.

### **Outcomes and Dissemination**

The findings of this study will be published in peer reviewed academic journal articles, which sit at the intersection between the clinical practice of psychotherapy and psychotherapy research. The work is predicted to be of interest to clinicians and researchers interested in therapeutic integration as well as therapeutic divisions and polarities (and ways to overcome these).

- Peer reviewed journals
- Academic scholars and researchers
- Therapists and clinical practitioners

The findings from this study will:

- Further our appreciation of how qualified BABCP accredited CBT therapists and BPC accredited psychodynamic practitioners understand, perceive and, potentially, integrate, psychodynamic and CBT principles in private practice.
- Increase awareness of some of the possible challenges of therapeutic integration processes.
- Provide understanding for psychotherapeutic practitioners on addressing complex patient needs which may require clinically diverse treatment interventions.
- Suggest further recommendations for clinicians in private and public practice regarding therapeutic integration.

### **Study Limitations**

The principal limitation of this study is the generalizability of data, given that our participant sample will range between 25-50 therapists based in the UK. It is therefore difficult to gauge the broader therapeutic attitudes and perceptions toward CBT and psychodynamic psychotherapy and therapeutic integration more broadly, given the geographical spread and demographic diversity of the global therapeutic community. However, the



qualitative approach will allow our study to identify important idiosyncratic perceptions and feelings toward therapeutic integration and clinical concepts from other modalities in a way that would not be possible in quantitative research.

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