The Ups and Downs of Cognitive Therapy Training: What Happens to Trainees' Perception of their Competence During a Cognitive Therapy Training Course?

James Bennett-Levy

Oxford Cognitive Therapy Centre, UK

Alexis Beedie

St Mary's Hospital, Kettering, UK

Abstract. One- and two-year cognitive therapy training programs are increasingly popular in the UK and overseas. Previous research has indicated that trainees show gains in competence, though this may at times be accompanied by self-doubt and stress. The present study sought specifically to gain the trainees' perspective: What happens to self-perception of competence (SPC) during cognitive therapy training – does it change over time? Do all elements of cognitive therapy skill show the same changes in SPC? Do individuals show different patterns of change? What environmental and internal factors influence changes in SPC? Twenty-four trainees on a one-year part-time training course completed a self-rated assessment of competence at six time points during the course. They also reported attributions about experiences that might have contributed to increases or decreases in SPC. Results demonstrated that SPC increases significantly over time, but there is considerable variation across different skills, and between individuals. A model developed from trainees' qualitative data indicated that the prime influences on SPC were new learning opportunities (acquiring knowledge, implementing knowledge, external evaluation, experiences with clients), self-reflection on performance, increased awareness of the standards required of a cognitive therapist, and emotional state, in particular emotionally salient memories and current stress. Practical implications of the findings for trainees, trainers and supervisors are discussed.

Keywords: Cognitive therapy training, therapist competence, supervision, self-reflection, grounded theory.

Introduction

It is a basic tenet of psychotherapy education and training that competence is necessarily related to positive patient outcomes. However, little is known about how therapist competence is acquired. Reassuringly, in the last 15 years, empirical evidence has started to suggest that:

1. Therapist competence is indeed related to patient outcome in studies of psychotherapy (Blatt, Sanislow, Zuroff and Pilkonis, 1996; Luborsky, McLellan, Digner, Woody and Seligman, 1997) and cognitive therapy (Kingdon, Tyrer, Seivewright, Ferguson and Murphy, 1996; Shaw et al., 1999; Trepka, Rees, Shapiro, Hardy and Barkham, 2004).

2. Psychotherapy training courses may enhance trainee competence (Alberts and Edelstein, 1990; Crits-Christoph et al., 1998; Greenberg and Sarkissian, 1984), though in some instances, technical adherence can be improved at the expense of alliance factors (Henry, Strupp, Butler, Schacht and Binder, 1993; Stolk and Perlesz, 1990). In studies of cognitive therapy training, several authors have demonstrated improvement in trainee competence with training (James, Blackburn, Milne and Reichfelt, 2001; Milne, Baker, Blackburn, James and Reichelt, 1999; Williams, Moorey and Cobb, 1991).

   What is unclear at this stage is precisely what training processes contribute to enhanced competence (Bennett-Levy, 2006); nor is it clear how competence develops over time, or whether different skills and trainees improve at similar or different rates.

A separate, but related, issue is the difficulty experienced by trainees on training courses. Two of the more common elements are self-doubt about competence (Duryee, Brymer and Gold, 1996) and the stress of undertaking cognitive therapy training courses, which I. M. Worthless, U. R. Competent and O. Lemonde-Terrible (2002) articulated in their landmark paper describing the syndrome of Cognitive Therapy Training Stress Disorder.

Although we are not aware of any specific empirical data relating therapist self-confidence or self-perception of competence to patient outcomes, it seems likely that high or low self-confidence is related to actual therapeutic performance and therefore to patient outcomes. For instance, Milne, Claydon, Blackburn, James, and Sheikh (2001) added the category charisma/flair to their revised version of the Cognitive Therapy Scale (CTS-R), partially to reflect this element of therapist competence; and Dobson and Shaw (1993, p. 574) have written: "Our perception is that more skilled cognitive therapists are those who establish a mutually respectful relationship with their patients, in which they combine their compassion for the patient's suffering with a sense of competence and confidence". If researchers can understand the process of training better, then it may be possible to alleviate some of the stress and doubts about competence that may impact on therapist performance and patient outcomes, and may sometimes affect trainees' emotional wellbeing.

With the increasing popularity of 1–2 year part-time cognitive therapy training courses in the UK and Europe (e.g. Denmark, Poland, Sweden), the present study focused on the experiences and perceptions of cognitive therapy trainees at six time-points during a one-year part-time cognitive therapy diploma training course. It sought specifically to address the following questions:

  (i)   Does self-perception of competence (SPC) change over time?
 (ii)   Does SPC show the same changes over time for all elements of cognitive therapy skill?
(iii)   Is there individual variation in changes in SPC?
(iv)   What environmental and internal factors influence changes in SPC?

As several writers have noted (Bennett-Levy et al., 2001; Piercy and Thomas, 1998; Street, 1997), the trainee's voice has been relatively absent in the training literature, yet here are a sophisticated set of observers who are central to the process, and may be in a unique position

to contribute some valuable observations. Hence, trainee self-perceptions were the specific focus of the study.

Some authors have justifiably argued that trainees' perceptions may not necessarily reflect objective reality (e.g. comparing self-ratings with objective ratings, James et al., 2001; Perlesz, Stolk and Firestone, 1990). However, there are also problems with "objective" ratings of competence (e.g. CTS Scale, Whisman, 1993), as well as the selected nature of the tapes trainees present for marking, which mean that they too do not tell the whole story. Regardless of the relative merits of "objective" and "subjective" ratings, SPC is an important area of study in itself, and the study of trainees' perceptions of influences on their SPC may yield data unavailable or difficult to obtain by more objective means.

Based on previous studies of trainee therapist development, it was our expectation that:

1. Trainees as a group should experience themselves as becoming more competent over time (Milne et al., 1999; Williams et al., 1991).
2. Some aspects of therapeutic skill (e.g. technical skills) might improve more than others (e.g. interpersonal skills), and this might be reflected in SPC ratings (Henry et al., 1993; Milne et al., 1999; Stolk and Perlesz, 1990).
3. There would be considerable individual variation in self-perception of competence over the time course (Perlesz et al., 1990).

Since neither the trainees' experience of training nor SPC have been systematically studied in previous cognitive therapy literature, there seemed little basis for predicting which factors would be likely to contribute to increases or decreases in SPC. Accordingly, for this part of the study, we used an open-ended approach to yield written data that could be subjected to qualitative analysis.

Method

Participants

Participants were 24 trainees undertaking the Cognitive Therapy in Oxford one-year diploma in cognitive therapy. Median age was 36 years; 87% were female. Fifty percent had prior cognitive therapy experience with less than 20 patients, 30% had seen more than 100 patients; 58% had had professional qualifications for more than 5 years. Clinical and counselling psychologists comprised the largest professional group (67%); 21% were nurses; 12% psychiatrists.

Course

The one-year diploma is an intensive, well-regarded cognitive therapy training program. Trainees attend the Oxford course one day a week for supervision and workshops with an emphasis on experiential training. Homework and course assessments include guided reading, assessed clinical work (audiotapes), case reports and essays. Entry requirements to the course include basic knowledge of and skill in cognitive therapy, and current cognitive therapy practice. Selection is via competitive interview.

Materials

The Cognitive Therapy Self-Rating Scale (CTSS) was developed by one of the authors (JB-L) to provide an ongoing assessment of participants' self-perception of competence in using cognitive therapy skills. The CTSS is a modified *self-assessment* version of Young and Beck's (1988) *supervisor-rated* Cognitive Therapy Scale (CTS), which has 13 items divided into three subscales, General Interview Procedures (4 items: agenda setting, client feedback, collaboration, pacing and efficient use of time), Interpersonal Effectiveness (3 items: empathy, interpersonal effectiveness, professionalism) and Specific CBT Techniques (6 items: guided discovery, case conceptualization, focus on key cognitions, cognitive techniques, behavioural techniques, homework). Like the CTS, the CTSS also consisted of these 13 items. Participants estimated current level of competence using a 10-point Likert scale ranging from No skill at all (1) to Master skill level (10).

Additionally, we wanted to identify what environmental and internal factors influenced changes in SPC. Therefore an open-ended response form was developed to collect participants' ideas about the reasons for the changes in rating of each item between one assessment occasion and the next. For details of the response form, see the next section.

We also report for comparative purposes some supplementary data comparing supervisor-rated CTS ratings at first assessment, within weeks of the start of the course, and at the final assessment. It should be noted that these ratings were made by different supervisors; hence their reliability can only be regarded as approximate. They are included because they are relevant and of obvious interest, and provide a degree of external validation for the self-report data; however, SPC was always the primary focus of the study.

Procedure

At the start of the course, the purpose of the study was explained, and all participants agreed to participate. Data were obtained from all participants on 100% of occasions that they were available (one participant went on maternity leave during the course). The CTSS was given to participants at the start of the course, and thereafter every six to seven weeks. This produced six occasions for assessment.

On the last five occasions, participants first completed the CTSS, and then opened a sealed envelope with their CTSS scores from the last assessment occasion. Next they wrote the present and previous scores for each item on the open-ended response form. If their score had increased by two or more points, or decreased by one point or more, they completed a section of the form headed "Beliefs regarding change in ratings over time". They were asked to "try to relate your ideas about reasons for change to specific events, life circumstances, or fluctuations in mood/confidence, which may or may not be directly related to changes in cognitive therapy skills". Two examples were provided.

The criteria for triggering "increase" and "decrease" observations were set at $+2$ and -1 points respectively because: (i) at the outset we considered it likely that there would be far more increases in SPC score than decreases; (ii) our aim was to have a roughly similar number of "increase" and "decrease" observations so that beliefs regarding change would not be skewed in one direction; and (iii) we did not wish to overburden our participants with commenting on every small change. In the event our prediction proved accurate. This procedure yielded a total of 327 qualitative observations, 184 for increases in SPC, and 143 for decreases in SPC.

Data analysis

Quantitative data. The present study reports summary scores from the three subscales of the CTSS (General Interview Procedures, Interpersonal Effectiveness, and Specific CBT Techniques) and a total CTSS score. As a check on the internal consistency of the CTSS, Cronbach's alphas were computed for the three subscales and the Total CTSS score. Results were $\alpha = .78$ for General Interview Procedures, $\alpha = .92$ for Interpersonal Effectiveness, $\alpha = .87$ for Cognitive Behavioural Techniques, and $\alpha = .93$ for the Total CTSS score, indicating adequate internal consistency of the scale. Due to the number of comparisons being made in the study, probability was set at the .01 level.

Qualitative data. Since the purpose of the study was to derive a preliminary model of factors influencing SPC, grounded theory methodology (Glaser and Strauss, 1967; Pidgeon, 1996; Strauss and Corbin, 1990), the purpose of which is specifically to develop theory in new areas of research, was considered suitable for this purpose. Grounded theory has a rigorous and well-described set of analytic methods. They include the constant comparison method, theoretical sampling, memoing, category definition, negative case analysis, and prolonged exposure to the data (Glaser and Strauss, 1967; Strauss and Corbin, 1990). These methods are bolstered by a series of procedures to enhance the credibility of the data (the qualitative researcher's equivalent of reliability and validity) e.g. multiple analysts, assessment checks on researchers' coding, external auditor, bracketing of researchers' presuppositions, data saturation, triangulation, and member checking.

Grounded theory data analysis proceeds through three levels using the constant comparison method: (i) the initial coding of the data (known as "open coding"); (ii) the development of higher order categories that link lower order codes together; and (iii) the development of theory that describes and defines the relationship between categories. The evolution of a grounded theory starts at the first data analysis with formative hypotheses. The constant comparison method allows the evolving theory to be constantly evaluated and modified against new data.

In the present study, the authors analysed the data collected at the first assessment occasion to derive preliminary categories. These categories were then combined to create more cohesive higher-order categories, which continued to evolve throughout the duration of the project. Once 90% concordance for categories had been obtained between the researchers, one author (AB) coded the data from the next two time-points. An independent check by the other author (JB-L) and an external auditor unconnected with the study revealed high concordance for categories (Cohen's kappa = .90 and .93 after correcting for chance). Following discussion between the authors and the external auditor, the category definitions were refined to increase clarity and reliability so that further independent and joint analysis produced 100% agreement.

At this stage, data saturation was thought to have been achieved, and we moved from category descriptions to a preliminary causal model, based on the researchers' analyses. The model was presented to the study participants for "member checking", a procedure to determine how well the model fits with experience. Some modifications were made in the light of feedback.

Next, the remaining data from the final two time-points (third term of the course) were coded by both researchers. Almost all data fitted well with previously developed categories and themes, except that, interestingly, a further significant category emerged, *Ending the course*, which could not have been predicted from the previous data.

In the final stages of the model's evolution, it was presented to participants at a major international cognitive therapy conference (Beedie and Bennett-Levy, 2004), and to two other

Table 1. Means and standard deviations (in parentheses) on the 3 CTSS subscales over 6 time-points (T)

Subscale	T_1	T_2	T_3	T_4	T_5	T_6
General interview procedures	14.2	16.2	17.7	20.6	21.4	22.0
(range: 0–40)	*(4.9)*	*(4.4)*	*(4.8)*	*(5.1)*	*(5.0)*	*(5.4)*
Interpersonal effectiveness	16.5	16.4	17.3	18.3	19.1	19.3
(range: 0–30)	*(4.5)*	*(4.1)*	*(4.3)*	*(4.3)*	*(4.3)*	*(4.7)*
Cognitive behavioural techniques	18.7	21.5	25.3	29.7	30.2	31.9
(range: 0–60)	*(6.9)*	*(7.0)*	*(6.3)*	*(7.4)*	*(7.2)*	*(7.6)*

UK groups of cognitive therapy trainees. Feedback from these groups and further evaluation led to small modifications in the model to achieve the best "fit" with the reported experience of trainees.

Results

Quantitative analyses

Participants reported a significant increase in Total CTSS score between the 1st and 6th time points ($t = -7.38$, $df = 22$, $p < .001$). Repeated measures analysis of variance (using Greenhouse-Geisser corrections) revealed significant increases on each of the subscales: General Interview Procedures: $F_{(2.6,58.0)} = 26.5$, $p < .001$; Interpersonal Effectiveness: $F_{(3.0,65.3)} = 7.0$, $p < .001$; Cognitive Behavioural Techniques: $F_{(2.7,59.7)} = 43.6$, $p < .001$). Table 1 details results on these three subscales across the six time-points. In answer to our study question 1, SPC does indeed show significant changes over time.

Post hoc tests revealed that the time course and magnitude of these gains varied. General interview procedures showed a significant increase between 1st and 3rd time-points ($t = -3.6$, $df = 23$, $p = .002$), and this also increased significantly to the 4th time point ($t = -6.1$, $df = 23$, $p < .001$), and then plateaued (see Table 1). The only significant difference in interpersonal effectiveness was between the 1st and 6th time points ($t = -3.2$, $df = 22$, $p = .004$). On cognitive behavioural techniques, there were significant increases between the 1st and 3rd time-points ($t = -6.3$, $df = 23$, $p < .001$), between 3rd and 4th ($t = -4.4$, $df = 23$, $p < .001$), and with a borderline significant increase between the 4th and 6th ($t = -2.8$, $df = 22$, $p = .012$). Therefore, the data suggest in answer to study question 2 that SPC for different cognitive therapy skills shows different patterns of change over time.

The group data masked considerable individual variation – for instance, while the group data suggested progressive gains in SPC across time, a minority of trainees showed decreases in Total CTSS score between one assessment and the next – for instance, three trainees between 1st and 2nd time point, two between 3rd and 4th, and five between 5th and 6th. For specific skills, individual variability was greater still. Despite the strong trend for mean SPC ratings to increase over time, the percentage of trainees showing decreases on at least one item between one time-point and the next were 88%, 80%, 57%, 83% and 96% over the five comparison periods. To illustrate this point, Figure 1 shows the scores for a randomly selected group of participants on a randomly selected skill (guided discovery). Thus, in answer to study question 3, while there is a general trend for scores to increase, any given individual may show an increase, decrease or no change at different time points for different skills.
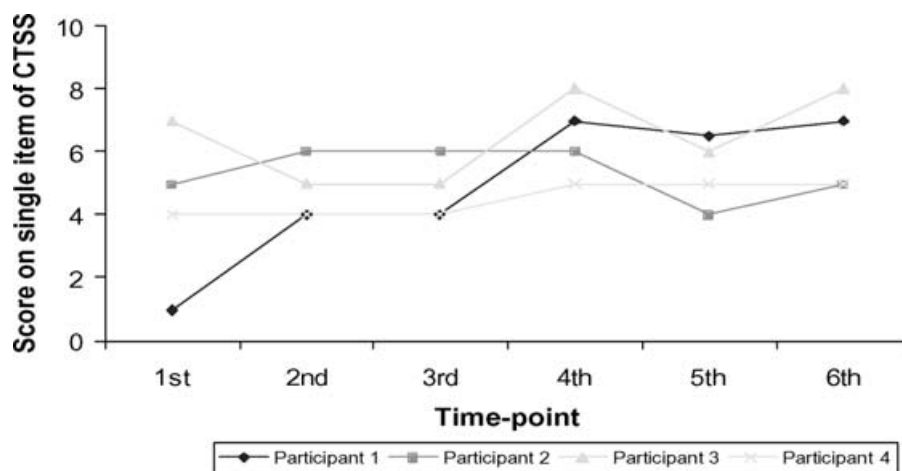
Figure 1. Changes in Self-Perception of Competence on a randomly selected item "Guided Discovery" in Cognitive-Behavioural Techniques subscale, over 6 time-points for 4 randomly selected participants

Table 2. Comparison of mean supervisor ratings on the Cognitive Therapy Scale (CTS) between first and last assessments during the course

	Mean ratings – first assessment (Early Term 1)	Mean ratings – final assessment (Late Term 3)	Difference
General interview procedures	12.4	15.7	$t = -3.83$**
(range 0–24)	*(3.2)*	*(3.3)*	
Interpersonal effectiveness	13.1	15.1	$t = -3.05$*
(range 0–18)	*(1.8)*	*(2.5)*	
Cognitive behavioural techniques	15.9	23.1	$t = -4.92$***
(range 0–36)	*(4.6)*	*(5.2)*	

*$p < .007$, **$p = .001$, ***$p < .001$.

Data from the supervisor-rated CTS displayed similar kinds of change to the trainee-rated CTSS, with considerable positive change in the cognitive behavioural techniques and interview procedures subscales, and smaller but still significant changes in interpersonal effectiveness (see Table 2).

Qualitative analysis

The process of the grounded theory analysis was undertaken in various stages: first, the initial 1/5th of the data was analysed, then the next 2/5ths, then the next 2/5ths. Eighteen categories emerged from the initial analyses. They were combined and re-combined through use of the constant comparison method into higher order emergent themes.

As is typical in qualitative analysis, the earlier categories to emerge were "participant categories", directly derived from participant's observations (e.g. *Feedback from supervisor, Targeting specific skills to practice*). Later categories (*e.g. New learning, Emotionally salient*
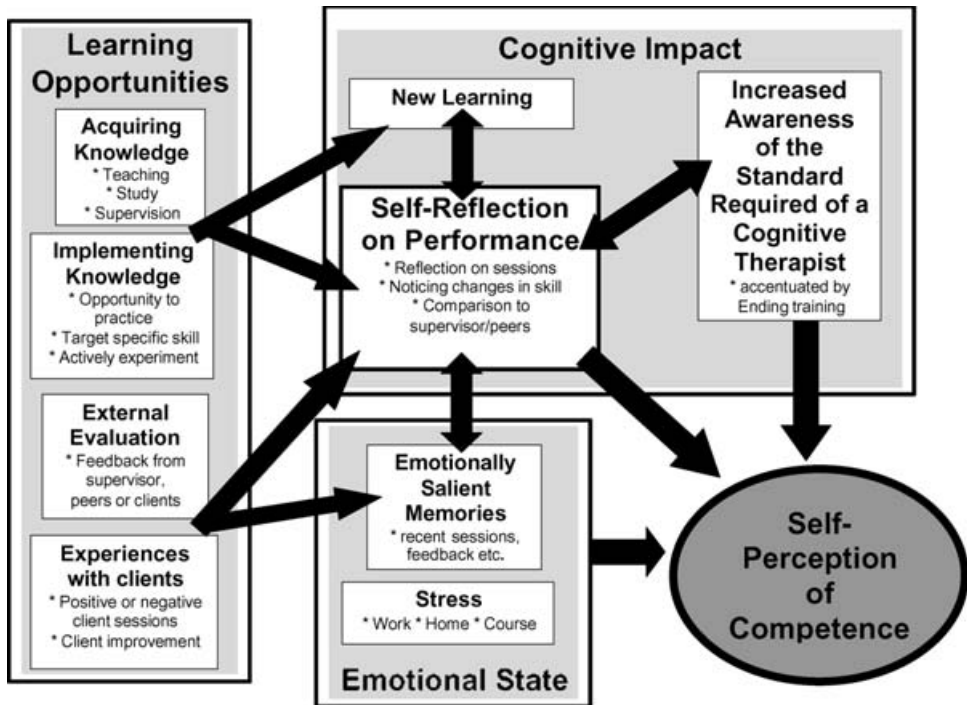
Figure 2. Model of the Influences on Self-Perception of Competence

memories), and higher order themes (*Learning opportunities, Cognitive impact, Emotional state*) were "researcher categories", emergent with greater immersion in the data. The arrows in Figure 2 indicate the inferred causal relationships resulting from the analyses of the relationships between categories.

Figure 2 displays the model that emerged from a process of gradual refinement over a year and a half, incorporating ongoing analysis via the constant comparison method, use of an external auditor, member checking, and feedback from other trainee groups. The analysis suggests that three major components determine SPC: the *Learning opportunities* experienced by the participant; their *Cognitive impact*; and the trainee's *Emotional state*. Descriptions and examples of the categories that form these components are given in Tables 3, 4 and 5.

The model suggests that various kinds of learning opportunity have cognitive, and sometimes emotional, impacts. Some learning experiences have greater emotional salience than others. In particular, *External evaluation* and positive or negative *Experiences with clients* can produce emotionally salient memories (see arrowed links), which were hypothesized to play prominent role in self-ratings of competence. Other learning experiences (e.g. reading, or trying out new interventions with clients) are focused primarily on acquiring conceptual, interpersonal and technical knowledge, and procedural skills. These experiences appear to have greater cognitive than emotional impact (see arrows), unless they also involve experiences with clients or external evaluation.

Table 3. Description of *Learning opportunities* categories

Category	Subcategories	Description	Sample quotes
Opportunities for acquiring knowledge	∗Teaching ∗Supervision ∗Study	Formal learning from lectures, role-plays, supervision of course clients, essays, reading etc.	"I wrote my first essay on conceptualization which gave me good knowledge to use in clinical practice"
Opportunities for implementing knowledge	∗Opportunity to practice ∗Targeting a specific skill ∗Actively experiment	Having appropriate clients who attend sessions, focusing on specific skills, and experimenting with techniques	"Unfortunately I have had several weeks of patients rearranging appointments, which has led to decreased opportunities to apply techniques consistently"
External evaluation	∗Feedback from supervisor, ∗or peers ∗or clients	Specific comments from supervisors, peers or clients highlighting particular aspects of skill	"More experienced others felt empathy was one of my strengths"
Experience with clients	∗Positive sessions ∗Negative sessions ∗Client improvement	Clients making progress, experiencing success, being motivated – or the opposite	"In struggling to conceptualize with this term's client, I've lost my confidence in my ability to gain feedback"

Potentially, all the various learning opportunities may help to refine this knowledge through self-reflection on performance. As Figure 2 indicates, *Self-reflection on performance* is the fulcrum of the model, the engine that connects the various elements. Twenty-one percent of total participant observations referred directly to self-evaluation, self-reflection or self-comparison, particularly in the contexts of supervision, sessions with patients, use of audiotapes, and comparison with supervisor's or peers' skills.

Another important emergent theme was *Increased awareness of the standards required of a cognitive therapist*. Participants often noted how their knowledge of what it took to be a competent cognitive therapist had changed. Two-thirds of *Increased awareness* observations were associated with decreases in SPC. For some, this was particularly salient as the end of the course approached, and they realised that they were not the "finished article". In the model, both *Self-reflection on performance* and *Increased awareness of standards* play important roles in determining SPC, and have a symbiotic, facilitative relationship (see double arrow). Self-evaluation and self-reflection appears to promote increased awareness of the standards required of a cognitive therapist, which in turn impacts on the evaluative/reflective process.

The other major determinant of SPC is *Emotional state*. One hundred percent of trainees' references to *work, personal or course stress* were associated with decreases in SPC. It was

Table 4. Description of *Cognitive impact* categories

Category	Subcategories	Description	Sample quotes
New learning	–	New declarative and procedural learning derived from chance to acquire and implement knowledge	"I've been practising this, its one of my goals, and I think I've improved through practice and rehearsal"
Self-reflection on performance	∗Reflection on sessions ∗Sense of skills becoming habitual ∗Comparison with peers/ supervisors	Self-evaluation during or post-sessions, listening to tapes, reflection on skill level through self-assessment, or comparison with others	"I have a little more experience, and have seen that my peers are making progress at about the same rate as me – I'm not as unskilled as I thought"
Increased awareness of the standard required of a cognitive therapist	∗Ending training ∗Supervision ∗Supervisor/ peer comparison	During training, participants develop new understandings of cognitive therapy competency. This is particularly highlighted as the course nears completion	"The course is nearing its end, and I am more aware now than at its beginning just how little I know"

Table 5. Description of *Emotional state* categories

Category	Subcategories	Description	Sample quotes
Emotionally salient memories	–	Recent events (e.g. good or bad sessions or positive or negative feedback) that form a prominent basis for judgments of competence.	"A patient recently gave feedback positively regarding collaboration, which I think has contributed to my increased rating"
Stress	∗Work ∗Home ∗Course	Indications of stress at work, home, or due to the course	"Generally high work stress levels I believe perhaps impact on my ability to demonstrate empathy"

also notable how *emotionally salient memories* – either positive or negative – could have what seemed like a disproportionate impact on sense of competence in these training practitioners. Hence, a recent positive or negative experience with a patient, or feedback from a supervisor, could significantly colour SPC.

In summary, the model identifies four elements – New Learning, Self-reflection on performance, Increased awareness of the standards required of a cognitive therapist, and Emotional state (primarily a function of emotionally salient memories and stress) – as the immediate determinants of SPC in trainee cognitive therapists.

Discussion

The present study has demonstrated that trainees' SPC increases significantly during a one-year cognitive therapy diploma course. In particular, there are marked gains in SPC for the structural aspects of CBT (General interview skills) and for technical interventions (Cognitive behavioural techniques), with smaller gains in interpersonal aspects (Interpersonal effectiveness). These differences in self-ratings on CTSS subscales closely mirror differences in the supervisor ratings of competency, based on ratings of trainees' tapes at the beginning and end of training, thus suggesting some degree of external validity. Indeed, given the amount of formal and informal feedback that trainees get during the course (at least six rated tapes, plus weekly supervision), it would be surprising if self-ratings did not have some external validity.

The gains in trainees' self-rated competence are broadly consistent with studies in the literature (e.g. Milne et al., 1999), which have assessed supervisor-rated competence. For instance, Milne et al. (1999) reported overall gains on CTS-R on a similar one-year diploma course. Both studies suggest that use of Cognitive behavioural techniques show significant gains during training. Though the Milne et al. study does not show gains on the structural aspects of CBT (General interview procedures here), the authors suggest that this is because the first measure was taken after a one-week induction course during which training on these aspects of therapy (e.g. agenda setting, client feedback) may already have had an effect. The present study, which found that most of the self-reported gains on structural aspects of therapy happened in the first half of the course, provides some support for this interpretation.

While the Milne et al. study showed significant gains in interpersonal skills, in the present study Interpersonal effectiveness showed the smallest gains (although still statistically significant) on both supervisor and self-ratings. One reason for this is that, compared with the other two subscales, there are fewer items (3 vs. 4 and 6), so variability is lower. It is also likely that Interpersonal effectiveness skills were more developed than the structural and technical skills of CBT at entry to the course, since high level of empathy was one of the key inclusion criteria for admission. Indeed mean scores for Interpersonal effectiveness were consistently higher than other supervisor- and self-ratings at first assessment. However, it is also possible that, as Henry et al. (1993) and Stolk and Perlesz (1990) have previously found, concentration on technical aspects of therapy during training can attenuate development of interpersonal skills. It has been suggested that one way to mitigate any deterioration of interpersonal skills during training may be to include a component of self-practice of cognitive therapy techniques, and self-reflection (Bennett-Levy and Thwaites, 2006; Bennett-Levy, Lee, Pohlman, Travers and Hamernik, 2003). The first term of the course, but not later terms, included some self-practice.

The grouped data masked considerable individual variation in self-perception of competence across different skills. Although generally trends in SPC were in a consistently positive direction, almost all participants rated themselves as less competent than previously on at least

one item at some point during training. Similar individual variation across time has been noted by Perlesz et al. (1990) on a family therapy training course.

The qualitative aspect of the study suggested that key elements in the judgment of SPC were self-reflection on recent learning and performances, increased awareness of the standards required of a cognitive therapist, and emotional state, derived from emotionally salient memories and current levels of stress. The centrality of self-reflection in the development of therapist competence, and self-perception of competence, is consistent with the work of Skovholt and Rønnestad, Schön and Bennett-Levy (Bennett-Levy, 2003, 2006; Schön, 1983; Skovholt and Rønnestad, 1992, 2001), who have all emphasized the role of self-reflection in professional development. Although researcher bias could have influenced the analysis and interpretation of the data, since one of the authors (JB-L) has previously suggested the importance of self-reflection in therapist development, three factors render this conclusion unlikely. First, as qualitative researchers, the authors were keenly aware of this possibility. Therefore, they "bracketed their presuppositions" prior to the analysis, and took proactive steps to guard against bias through inclusion of an external auditor and the majority of analysis being undertaken by the co-researcher (AB). Second, the very structure of the course actively promoted self-evaluation and reflection: weekly supervision groups, self-rating and supervisor-rating of tapes, and an experiential approach to training. Third, and perhaps most tellingly, was the sheer weight of the data that supported the theme Self-reflection on performance: 21% of all participant observations.

Increased awareness of the standards required of a cognitive therapist also emerged as a significant influence on judgements of SPC. During a course, trainees' understanding of the skills required of a cognitive therapist undergo considerable evolution; the more they know, the more they realise what they do not know, and this awareness can act at least temporarily to depress self-ratings (in two-thirds of Increased awareness observations in the present study). These data closely mirror the conclusions of Skovholt and Rønnestad (1992), who noted that during the course of training, psychotherapists' reliance on external expertise to judge their performance decreases as they develop more of an internal sense of expertise.

Current emotional state also has a significant impact on SPC. Emotionally salient memories derived from events such as recent sessions with clients and feedback from supervisors can have significant effects on self-ratings. In particular, the effect of supervisor feedback on self-perception should not be underestimated. Current stressors may also play a role in judgments of competence.

There are several limitations of the present study, which should be borne in mind. First, the reliability and validity of the CTSS has not been formally established. Although in the present study the results were broadly consistent with supervisor ratings of competence, it would be helpful to establish the CTSS' credentials more formally. Second, the conclusions of the study would be strengthened by including supervisor-rated CTS data, rated by the same supervisors at the same time-points as the CTSS. However, unfortunately this was not practical. Third, the qualitative data are dependent on trainees' hypotheses for changes in SPC. Although these data are interesting in themselves, a body of research suggests that people's attributions about causes of behaviour change are not always reliable (Nisbett and Wilson, 1977). Fourth, some factors that might be presumed to influence SPC – notably, trainees' comparative levels of past experience – do not feature in the model because grounded theory methodology dictates that models are "grounded" in the data collected during the study. In the present study, participants did not report differences in past experience of CBT as a factor. Their attributions for changes

in SPC seem to have been almost exclusively *intrapersonal*. Fifth, the SPC model is a tentative model derived from qualitative data. As a next step, it needs to be tested in a different cohort of trainees, preferably in a quantitative study.

While the above caveats should be borne in mind, the results of the study suggest a number of practical implications for supervisors, trainers, trainees on specialist CBT courses, and therapy trainees in other environments (e.g. clinical psychology or psychiatry training). First, trainees should be made aware that fluctuations in levels of self-confidence are quite normal. Awareness of the influences on such fluctuations may be helpful in mitigating their impact, and normalizing the experience. They should know that experiences of temporary setbacks, difficult sessions with clients, and a volatile sense of self-competence are to be expected. This may be accentuated as the course draws to a close, and trainees realize that they still have much to learn.

Second, it may be helpful for trainees to realize that their awareness of the standards required of a competent cognitive therapist is likely to change over time. Some trainees may have a feeling that the bar is always just out of reach. Again, this is quite a normal aspect of trainee development. Understanding this effect may help to lessen its impact.

Third, on those occasions when we have presented this research to cognitive therapy trainees, the feedback has been that it would be very helpful to be made aware of these issues at their start of the course. Doing so may prevent trainees becoming disillusioned or deskilled. Training course directors might consider including this paper as part of their orientation program.

Fourth, course supervisors and trainers may also benefit from understanding some of the influences and experiences of trainees identified in this paper. Given the powerful influence of supervisor feedback, it could be useful for trainees and supervisors to discuss the most helpful ways to provide feedback so that positive impacts are maximized. Another helpful exercise could be to identify a set of protective cognitions that might ameliorate any temporary loss of confidence.

In summary, although cognitive therapy trainees can expect that their SPC will grow during the course of training, they can also expect that there will be fluctuations and temporary experiences of setback and relative loss of confidence. If trainees, trainers and supervisors are aware that this is an entirely normal experience for trainees, then they can take steps that anticipate such problems, and may lead to a more benign experience of the learning process.

Acknowledgements

References

Alberts, G. and Edelstein, B. (1990). Therapist training: a critical review of skill training studies. *Clinical Psychology Review*, *10*, 497–511.

Beedie, A. and Bennett-Levy, J. (2004). *I'm not as unskilled as I thought: influences on self-perception of competence during therapy training*. Paper presented at the European Association for Behavioural and Cognitive Therapies XXXIV Annual Congress, Sept.

Bennett-Levy, J. (2003). Reflection: a blind spot in psychology? *Clinical Psychology, July*, 16–19.

Bennett-Levy, J. (2006). Therapist skills: a cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy*, *34*, 57–78.

Bennett-Levy, J., Lee, N., Travers, K., Pohlman, S. and Hamernik, E. (2003). Cognitive therapy from the inside: enhancing therapist skills through practising what we preach. *Behavioural and Cognitive Psychotherapy*, *31*, 145–163.

Bennett-Levy, J. and Thwaites, R. (2006). Self and self-reflection in the therapeutic relationship: a conceptual map and practical strategies for the training, supervision and self-supervision of interpersonal skills. To appear in P. Gilbert and R. Leahy (Eds.), *The Therapeutic Relationship in the Cognitive-Behavioural Psychotherapies*. Routledge, London.

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B. and Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy*, *29*, 203–220.

Blatt, S. J., Sanislow, C. A., Zuroff, D. C. and Pilkonis, P. A. (1996). Characteristics of effective therapists: further analyses of data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, *64*, 1276–1284.

Crits-Christoph, P., Siqueland, L., Chittams, J., Barber, J. P., Beck, A. T., Liese, B., Luborsky, L., Mark, D., Mercer, D., Onken, L. S., Najavits, L. M., Thase, M. E. and Woody, G. (1998). Training in cognitive, supportive-expressive, and drug counseling therapies for cocaine dependence. *Journal of Consulting and Clinical Psychology*, *66*, 484–492.

Dobson, K. S. and Shaw, B. F. (1993). The training of cognitive therapists: what have we learned from treatment manuals? *Psychotherapy*, *30*, 573–577.

Duryee, J., Brymer, M. and Gold, K. (1996). The supervisory needs of neophyte psychotherapy trainees. *Journal of Clinical Psychology*, *52*, 663–671.

Glaser, B. G. and Strauss, A. L. (1967). *The Discovery of Grounded Theory*. New York: Aldine.

Greenberg, L. S. and Sarkissian, M. (1984). Evaluation of counselor training in gestalt methods. *Counselor Education and Supervision*, *23*, 328–340.

Henry, W. P., Strupp, H. H., Butler, S. F., Schacht, T. E. and Binder, J. L. (1993). Effects of training in time-limited psychotherapy: changes in therapist behavior. *Journal of Consulting and Clinical Psychology*, *61*, 434–440.

James, I. A., Blackburn, I.-M., Milne, D. L. and Reichfelt, F. K. (2001). Moderators of trainee therapists' competence in cognitive therapy. *British Journal of Clinical Psychology*, *40*, 131–140.

Kingdon, D., Tyrer, P., Seivewright, N., Ferguson, B. and Murphy, S. (1996). The Nottingham study of neurotic disorder: influence of cognitive therapists on outcome. *British Journal of Psychiatry*, *169*, 93–97.

Luborsky, L., McLellan, A. T., Digner, L., Woody, G. and Seligman, D. A. (1997). The psychotherapist matters: comparison of outcome across 22 therapists and 7 patient samples. *Clinical Psychology: Science and Practice*, *4*, 53–65.

Milne, D., Claydon, T., Blackburn, I. M., James, I. and Sheikh, A. (2001). Rationale for a new measure of competence in therapy. *Behavioural and Cognitive Psychotherapy*, *29*, 21–33.

Milne, D. L., Baker, C., Blackburn, I., James, I. and Reichelt, K. (1999). Effectiveness of cognitive therapy training. *Journal of Behavior Therapy and Experimental Psychiatry*, *30*, 81–92.

Nisbett, R. E. and Wilson, D. W. (1977). Telling more than we can know: verbal reports on mental processes. *Psychological Review*, *84*, 231–259.

Perlesz, A. J., Stolk, Y. and Firestone, A. F. (1990). Patterns of learning in family therapy training. *Family Process*, *29*, 29–44.

Pidgeon, N. (1996). Grounded theory: theoretical background. In J. T. E. Richardson (Ed.), *Handbook of Qualitative Research Methods* (pp. 75–85). Leicester: BPS Books.

Piercy, F. P. and Thomas, V. (1998). Participatory evaluation research: an introduction for family therapists. *Journal of Marital and Family Therapy*, *25*, 165–176.

Schön, D. A. (1983). *The Reflective Practitioner*. New York: Basic Books.

Shaw, B. F., Elkin, I., Yamaguchi, J., Olmsted, M., Vallis, T. M., Dobson, K. S., Lowery, A., Sotsky, S. M., Watkins, J. T. and Imber, S. D. (1999). Therapist competency ratings in relations to clinical outcome in cognitive therapy of depression. *Journal of Consulting and Clinical Psychology*, *67*, 837–846.

Skovholt, T. M. and Rønnestad, M. H. (1992). Themes in therapist and counselor development. *Journal of Counseling and Development*, *70*, 505–515.

Skovholt, T. M. and Rønnestad, M. H. (2001). The long, textured path from novice to senior practitioner. In T. M. Skovholt (Ed.), *The Resilient Practitioner: burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals* (pp. 25–54). Boston: Allyn and Bacon.

Stolk, Y. and Perlesz, A. J. (1990). Do better trainees make worse family therapists? A followup study of client families. *Family Process*, *29*, 45–58.

Strauss, A. and Corbin, J. (1990). *Basics of Qualitative Research: grounded theory procedures and techniques*. Newbury Park: Sage Publications.

Street, E. (1997). Family therapy training research: an updating review. *Journal of Family Therapy*, *19*, 89–111.

Trepka, C., Rees, A., Shapiro, D., Hardy, G. and Barkham, M. (2004). Therapist competence and outcome of cognitive therapy for depression. *Cognitive Therapy and Research*, *10*, 19–30.

Whisman, M. A. (1993). Mediators and moderators of change in cognitive therapy of depression. *Psychological Bulletin*, *114*, 248–265.

Williams, R. M., Moorey, S. and Cobb, J. (1991). Training in cognitive-behaviour therapy: pilot evaluation of a training course using the Cognitive Therapy Scale. *Behavioural Psychotherapy*, *19*, 373–376.

Worthless, I. M., Competent, U. R. and Lemonde-Terrible, O. (2002). Cognitive therapy training stress disorder: a cognitive perspective. *Behavioural and Cognitive Psychotherapy*, *30*, 365–374.

Young, J. and Beck, A. T. (1988). *The Cognitive Therapy Scale* (Unpublished manuscript). Philadelphia: Center for Cognitive Therapy.