EMPIRICALLY GROUNDED CLINICAL GUIDANCE PAPER

Use of self-practice/self-reflection (SP/SR) exercises for competency-based training and assessment in CBT

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Abstract

With the increased demand for psychological services, and particularly for cognitive behavioural therapy (CBT), it is vital that teaching programs offer effective training that produce skilled and competent clinicians. This paper reviews the limitations of traditional approaches to training within the field of psychology, in terms of the promotion of a breadth of declarative knowledge at the expense of a deep and nuanced understanding of cognitive behavioural theory and clinical competence. It also reviews issues with existing strategies for competency-based assessment of trainees learning CBT. To date, many of these appear to assess a range of competencies concurrently and to test trainees within complex environments. Such methods may fail to provide an opportunity for the assessment of specific areas of competence and/or confound the assessment itself. It may also result in the public being exposed to trainees who are yet to develop competence. Based on recent research in training methods within psychology at large, and in relation to CBT specifically, a model of competency-based training and assessment is presented to address these issues. This model extends the existing research on the use of the experiential self-practice/self-reflection (SP/SR) framework for training in CBT. It proposes that the use of discrete exercises within a SP/SR training program promotes a more in-depth and nuanced appreciation of cognitive behavioural knowledge and skills and increased clinical competence. Furthermore, such exercises are proposed to provide an avenue for assessing clinical competence in specific skills prior to the commencement of direct client services.

Key learning aims

(1) To review literature on training for the development of clinical competence.
(2) To review literature examining methods of assessing competence.
(3) To propose the use of experiential training through a SP/SR framework as a method for providing both competency-based training and assessment.

Introduction

With the wide dissemination of cognitive behavioural therapy (CBT) training, especially with the advent of stepped care initiatives, finding methods for competency-based training is important to ensure delivery of effective services (Beale *et al.*, 2020). While there is considerable research on the theory and application of CBT to the treatment of mental health difficulties (Butler *et al.*, 2006; David and Cristea, 2018), there has, until recently, been little research on how training methods relate to the development of trainees' competence in CBT (Bennett-Levy and Lee, 2014).

In terms of identifying areas of competence, professional working groups have highlighted both foundational and functional competencies for practising psychology in general. Foundational competencies identified included professionalism, reflective practice, scientific knowledge and methods, relationships, individual and cultural diversity, ethical and legal standards and policy, and interdisciplinary systems (Kaslow *et al.*, 2009). Functional competencies identified by the working groups included skills in assessment, intervention, consultation, and research/evaluation (Kaslow *et al.*, 2009). This was largely reiterated by von Treuer and Reynolds (2017), who state that for clinical psychology competencies in the assessment and formulation of client needs, the ability to design and implement evidence-based interventions, and the ability to evaluate the outcomes of such interventions are central to effective therapy. Unfortunately, traditional approaches to training have tended to focus more on demonstrations of declarative knowledge about these areas, rather than demonstrations of competency (Kaslow *et al.*, 2009; Pachana *et al.*, 2011). As an extension of this, methods for assessing competency in trainees are also limited. Such efforts have tended to focus on the assessment of competence over entire therapy sessions, which creates a complex assessment environment that may confound a trainee's ability to demonstrate their competence and may result in issues with the assessment of competence in specific skills (Fairburn and Cooper, 2011; Liness *et al.*, 2019b).

Over recent decades there has, however, been a growing interest in researching methods for training in CBT. Such research has tended to highlight the importance of experiential learning as a key component in training programs (Bennett-Levy and Finlay-Jones, 2018; Gale and Schröder, 2014; Thwaites *et al.*, 2017). These findings are now being incorporated into training guidelines for CBT, such as the Nation Health Service's curriculum guidelines in the UK (Liness and Muston, 2022). A model to emerge of such training has been that of self-practice/self-reflection (SP/SR; Bennett-Levy *et al.*, 2015). This method of training has been found to promote personal development, conceptual skills, clinical skills, and interpersonal skills (Bennett-Levy, 2019; Haarhoff *et al.*, 2011; Thwaites *et al.*, 2017). While this research involves self-reports of increased competencies, little has been presented on how such training could be applied to competency-based assessment of trainees (McGillivray *et al.*, 2015).

This paper sets out to summarise the issues and limitations with historical approaches to psychological training for the development of competence and with the existing methods of assessing trainees' competencies. Based on this review, it proposes a novel extension of the SP/SR framework for the purpose of competency-based training and assessment.

Psychology training and CBT: limitations and opportunities

Historically, training in psychology has tended to focus on course objectives for the acquisition of empirical knowledge and time spent (e.g. hours on clinical placement) in training as a proxy for competency (Kaslow *et al.*, 2009; Pachana *et al.*, 2011). The direct assessment of competencies, being the ability to integrate knowledge, procedures, skills, and to tailor these to a variety of individuals and contexts has tended to be overlooked (Kaslow *et al.*, 2009; Pachana *et al.*, 2011). As a result, a trainee may have declarative knowledge, but little skill in its application. This has been observed in research on competency in case formulations. Kuyken *et al.* (2005) found that only 44% of 115 early career professionals were able to develop 'good enough' formulations on a case study following specific training in the skill. In a similar study, Haarhoff *et al.* (2011) found that 61% of participants in a comparable program were able to achieve 'good enough' cognitive behavioural formulations following initial training in formulation.

Such difficulty with the translation of declarative knowledge to the development of competent skill in early training has been further suggested to then result in future difficulties with applying knowledge and skills that may be acquired later in a clinician's career, reducing the capacity for evaluating the relevance and effectiveness of interventions to a given context and promoting over-reliance on

information from 'authorities' (Stoltenberg and Pace, 2007). Supporting this, a study assessing CBT competence by practising clinicians reported that both those that self-identified as CBT-oriented and those that did not performed to a 'less than satisfactory' standard with CBT-specific behaviours (Creed *et al.*, 2016).

These findings can be explained by construal theory. In terms of construal theory, the development of concepts when learning can vary between a lower, more concrete construal and a higher, more abstract construal. Concrete construals involve more specific, idiosyncratic, and incidental information relating to a concept, while abstract construals provide more information about the general meaning and valence of a concept, promoting its integration with other existing knowledge (Trope and Liberman, 2010). In line with this theory, these results suggest that more didactic teaching and a focus on assessment of declarative knowledge may be insufficient in promoting the ability to develop a more abstract construal of psychological knowledge and skills, consequently resulting in a simpler, concrete construal of such knowledge and skills, and a subsequent rigidity to their application. The failure to develop a deeper, more abstract appreciation for cognitive behavioural theory has been suggested to result in a focus on technical eclecticism alone and to inhibit the ability to develop more complex case formulations (Trinidad, 2007).

The failure to develop a higher construal with regard to cognitive behavioural theory and practice may subsequently promote cognitive biases that result in over-estimations in how individuals perceive their knowledge and competence (McManus *et al.*, 2012; Waltman *et al.*, 2016). In particular, it may promote the Dunning-Kruger effect in clinicians. This is a cognitive bias whereby people with limited knowledge or competence in an area over-estimate their knowledge and competence (Kruger and Dunning, 1999). This is thought to be a result of the same lack of knowledge and competence, as this prohibits the meta-cognitive ability to assess their abilities as deficient, and they instead assume themselves to be competent. This is supported by research findings that those objectively rated as the least competent practitioners may demonstrate the greatest over-estimation, as they lack awareness of their own deficiencies (Brosan *et al.*, 2008; Dunning *et al.*, 2003). Consequently, this may result in the clinician failing to recognise a need for training or supervision to improve their practice, and the delivery of less effective or even harmful therapy to their clients (Beale *et al.*, 2020; Brosan *et al.*, 2008; McManus *et al.*, 2012). For less experienced trainees the self-assessment of competency has been more variable. Studies have suggested that this group can demonstrate both over-confidence in their abilities (Rozek *et al.*, 2018) and an under-estimation of their competence, potentially reflecting issues with self-confidence (McManus *et al.*, 2012). Complicating this may be the nature of the training provided, with self-assessments having been found to be more accurate when comparative feedback by expert evaluators is provided in training programs (Kaslow *et al.*, 2009; Waltman *et al.*, 2016).

A method of teaching that can help to resolve these issues is problem-based learning (PBL). While conventional teaching methods are generally associated with better knowledge retention in the short term, PBL has been demonstrated to have longer-term benefits that include greater knowledge retention and improved application of knowledge to practice (Kaslow *et al.*, 2009; Wiggins *et al.*, 2016). PBL aims to cultivate an investigative approach to learning while also promoting a sense of responsibility for one's own learning. It involves self-directed learning to solve problems, often utilising group exercises (Wiggins *et al.*, 2016). As a result, PBL has been suggested to provide for improved outcomes in problem-solving, in the ability to tolerate uncertainty, to increase flexibility in the ability to adapt theory to practice, and to increase skills for collaboration, while at the same time cultivating intrinsic motivation and autonomy for learning (Dunsmuir *et al.*, 2017; Wiggins *et al.*, 2016). Understandably, such training methods could therefore translate into enhanced outcomes for the development, and maintenance, of clinical competence.

In summary, psychological training methods focused primarily on the development of declarative learning is limited in the ability to promote a deeper level of understanding of the material covered and competency with skills. This tends to result in difficulties with adapting such knowledge and skills to new contexts and can potentially contribute to biases and over-confidence. A potential solution to this is the application of PBL strategies to training in psychological therapy. Incorporating such learning approaches into training programs would provide learning opportunities that promote a deeper construal of knowledge and skills covered, which results in a more nuanced understanding of the targeted knowledge and greater flexibility in the application of skills learnt through such methods.

Issues with existing measures of competence

Session rating scales

Shifting to a focus on competency-based assessment, there have been recent efforts to look at the assessment of trainees' competency levels from CBT training programs. These have tended to utilise rating scales to assess the trainees' overall competence for conducting therapy sessions with clients (Humphreys et al., 2017b; Liness et al., 2019b; Schmidt et al., 2018). The first issue of this approach is that it may result in competency assessments for some skills being overlooked. While these scales do attempt to measure competency with a range of specific therapy skills, not all skills are relevant to a given therapy session. Subsequently, assessment of competence with some skills may be overlooked as they were not pertinent to a given therapy session (e.g. a session may focus on cognitive restructuring, so there may be no opportunity for assessing competence in developing behavioural experiments). Another issue with this approach is that it assesses competency within a complex environment. While demonstration of competency within complex environments is ultimately of importance, for novice clinicians it would be beneficial to assess competency levels with specific skills that are required within sessions prior to assessing complete sessions. This is akin to assessing a football player's individual passing, shooting and tackling skills, as opposed to assessing their overall game performances. Furthermore, like with skill development for sport, it is important to focus on specific skill development prior to their integration into an overall performance context. This is because performance contexts, like conducting entire sessions, provide multiple challenges (e.g. maintaining a dialogue, developing a formulation, planning an intervention, managing one's own emotional state), thereby increasing the cognitive load of the activity and potentially inhibiting the individual's capacity to demonstrate their skills and to learn (van Merriënboer and Sluijsmans, 2009). Scaffolding of the knowledge and skills that the individual is learning instead helps the learner to navigate challenges of increasing complexity and to develop an understanding of how the individual pieces of learning can be integrated into a greater framework (Coulson and Harvey, 2013; Taylor and Hamdy, 2013). In line with this, it has been suggested that shorter, more discrete clinical scenarios may provide for more reliable competency judgements over a longer session with a complex mix of strategies, as typically measured by session rating scales (Schmidt et al., 2018).

Use of therapy rating scales to measure competence also tends to be limited by the time taken to review sessions, often resulting in generalisations about competence being made from few recordings (Fairburn and Cooper, 2011). Furthermore, there is often a self-selection of sessions by trainees, allowing them to pick their best sessions rather than a more representative sample of their work (Liness et al., 2019a). Adding to this, there can be a lack of consideration for client variability (i.e. a lack of consideration for the challenges involved in addressing the clients presenting difficulties; Fairburn and Cooper, 2011; Liness et al., 2019a).

Another issue with a number of the competency assessment tools is that they are designed for use once trainees have commenced, and even completed, direct client work (Humphreys et al., 2017b).

Establishment of a base level of competency prior to conducting client work would be beneficial to minimise the chance of trainees delivering ineffective or harmful therapy.

Role-plays (vs real-plays)

While standardised role-plays have been suggested as a way of addressing this, the limited research on the use of these role-plays has again tended to focus on overall session ratings (Liness *et al.*, 2019a). It has also been suggested that the use of 'real-plays', where a trainee takes the client role presenting real information from their own life for an exercise, is superior to role-plays (Lertora *et al.*, 2020; Nemec *et al.*, 2015). It has been suggested that this is because real-plays are experiential exercises that provide for a more authentic experience, avoiding constructed scenarios where the trainee may feel a pressure to act and may rely on pejorative and/or simplistic stereotypes, lacking nuance. As a result, they are thought to provide more realistic challenges for the practice of clinical skills and to normalise the processes upon which psychological dysfunction are often based, promoting the development of empathy (Lertora *et al.*, 2020; Nemec *et al.*, 2015).

Summary

Based on this review, using session rating scales as an initial method for assessing competence in trainees learning CBT appears to be problematic. They can fail to provide an opportunity for the assessment of specific skills and may provide a confounded or biased presentation of the trainee's competency levels. Waiting to use such scales until trainees have commenced direct client work also provides risks to the public. Use of experiential real-plays, as opposed to role-plays, appears to provide a strategy for learning specific skills and for assessing competency with these outside of a direct counselling environment, and prior to trainees engaging in direct client work.

The SP/SR training framework

Personal practice has long been considered an important form of experiential learning for those seeking to acquire clinical knowledge and skills. For a number of decades, personal practice activities have been recommended as an important method for learning the intricacies of cognitive behavioural therapy (Beck, 1995; Padesky, 1996). It has only been since the turn of the century, however, that such training methods have received attention, in terms of developing structured approaches and research on its training outcomes (Bennett-Levy *et al.*, 2015; Chigwedere *et al.*, 2019; McGillivray *et al.*, 2015). A prominent strategy to emerge from this literature has been the self-practice/self-reflection (SP/SR) framework developed by Bennett-Levy and his colleagues (Bennett-Levy *et al.*, 2015). This model was developed to help transition declarative learning into skill development (Bennett-Levy, 2006; Bennett-Levy *et al.*, 2001).

The SP/SR models provides a structured training framework that pairs the application and practice of cognitive behavioural theory and interventions to the self with reflective exercises (Thwaites *et al.*, 2014). It has three core elements: (1) the identification of a challenging problem, (2) self-practice, and (3) self-reflection (Bennett-Levy, 2019). The challenging problems can be either of a personal or professional nature, and it is suggested that these be of mild to moderate difficulty (i.e. not a major difficulty). These problems may then be used within the context of either individual or group exercises, in which the trainees gain self-practice as both a therapist and as a client, with self-reflection emphasised for experiences in both roles (Bennett-Levy *et al.*, 2015). The self-reflection focuses on their experiences both from a personal perspective and from a professional perspective, with guided questions. These reflective questions also include 'bridging' questions that are suggested to promote the translation of the trainees personal learning into professional learning, with regard to related theory, strategies, and interpersonal skills for clinical work (Bennett-Levy, 2019). The SR component is further highlighted as providing training in a

meta-competence that promotes ongoing learning from experience that can help with the refinement of clinical skills (Bennett-Levy *et al.*, 2009). Based on these descriptions, the framework can be considered to be a form of problem-based learning.

The research to date on the use of SP/SR as a training technique suggests that it is an effective training method, with studies supporting its use with novice therapists through to more experienced practitioners (Bennett-Levy and Lee, 2014; Bennett-Levy *et al.*, 2001; Chigwedere *et al.*, 2019; Collard and Clarke, 2020; Davis *et al.*, 2015; Thwaites *et al.*, 2014). Participants have typically reported a range of promising outcomes from this form of training. Amongst the benefits reported have been an enhanced confidence with, and understanding of cognitive behavioural theory, an increased appreciation for cognitive behavioural strategies, and greater skill in the application of techniques, including greater flexibility and nuance in their application (Bennett-Levy, 2019; Chigwedere *et al.*, 2019; Collard and Clarke, 2020; Collard and Clarke, 2022; Davis *et al.*, 2015; McGillivray *et al.*, 2015; Scott *et al.*, 2021). Participants also tend to report improved interpersonal skills, allowing for a greater attunement with clients and increased empathy for their presenting difficulties (Bennett-Levy *et al.*, 2015; Chigwedere *et al.*, 2019; McGillivray *et al.*, 2015; Thwaites *et al.*, 2014). More generally, participants typically noted that such training programs also result in an enhanced self-reflective capacity, greater self-awareness, and improved wellbeing (Bennett-Levy, 2019; Bennett-Levy and Lee, 2014; Gale and Schröder, 2014). Unsurprisingly, these findings are also consistent with the literature on 'real-plays' (*vs* role-plays), which also utilises self-practice, and claims to better promote skill development and empathy (Lertora *et al.*, 2020; Nemec *et al.*, 2015).

It is important to note that while training through SP/SR programs can be considered an engaging form of training, it can also be considered more challenging. Balancing the level of challenge provided in such programs is crucial for maximising learning outcomes for trainees, as excessive challenge can reduce engagement with it, which subsequently affects a trainee's ability to achieve positive learning outcomes (Bennett-Levy and Lee, 2014). A key factor that can negatively influence level of engagement with SP/SR training methods is anxiety, particularly in relation to worries about loss of control and social judgement (Bennett-Levy and Lee, 2014; Spendelow and Butler, 2016). Offsetting this are factors that promote positivity towards the model and help to reduce anxiety. These include expectations of benefit from the experience, structure, positive group dynamics, links to course outcomes, and a positive perceptions of coping resources (Bennett-Levy and Lee, 2014). A sense of control over the experience can also reduce anxiety, which can be encouraged by self-selection, control over the content of exercises, and control over the level of sharing about experiences (Bennett-Levy and Lee, 2014).

SP/SR as a form of competency-based training and assessment

While promising, the findings on SP/SR training programs are limited in terms of the assessment of actual improvements to competency levels, as they are predominantly based on self-report (McGillivray *et al.*, 2015). Despite this, the framework would appear to offer a potential method for developing and assessing clinical competency in a way that can address the concerns with self-reflection, with regard to the scaffolding of competency development and assessment, and in a context that does not provide risk to the public. In line with this, we propose a new extension to the SP/SR framework to enable its use as a form of competency-based training and assessment.

As noted above, self-assessment of competency allows for the influence of self-report biases, like the Dunning-Kruger effect (Dunning *et al.*, 2003; Kaslow *et al.*, 2009). To remedy this Pachana *et al.* (2011; p. 68) recommend that for the development of competency in clinical skills 'practice should be deliberate and guided by feedback regarding performance and how it compares with optimal performance'. This has been supported by research demonstrating that when paired with feedback from an expert supervisor, self-reflections become more accurate, with student and

supervisor ratings converging over time (Beale *et al.*, 2020; Brosan *et al.*, 2008; Kaslow *et al.*, 2009). The SP/SR framework allows for this, as it provides training in the practice of skills in a supportive framework that can provide feedback and guidance regarding the application of knowledge and skills (Bennett-Levy *et al.*, 2015).

A further suggested benefit of the SP/SR training model is that the pairing of guided feedback with self-reflections also helps to build competency in the use of self-reflection itself. The development of a capacity for self-reflective practice is considered to subsequently provide a lifelong competency, helping to develop and improve clinical skills into the future as well (Bennett-Levy *et al.*, 2009; Kaslow *et al.*, 2009). Within the SP/SR framework, guided feedback could act as a mechanism for helping trainees to assess their competency with both clinical skills and with self-reflection skills, as the expert ratings and feedback can help to provide assessment against established clinical standards. Ultimately, this could help to improve the trainee's ability to be more accurate in recognising their own competency levels and to enhance their confidence in their abilities (Scott *et al.*, 2021).

In terms of providing learning and assessment of competencies in a scaffolded manner, the SP/SR framework provides an avenue for trainees to practise and develop competency with specific skills outside the context of an overall therapy session. With the self-practice aspect of the SP/SR framework, trainees are required to practise formulation skills in relation to their own problems, to develop and apply interventions to these, and to then reflect upon what is learnt from these (Bennett-Levy *et al.*, 2015). While much of the SP/SR research has looked at outcomes from overall training programs, there have been a few studies that have focused on the learning outcomes from some specific exercises, including thought diaries, exposure tasks, and behavioural experiments (Bennett-Levy, 2003; Collard and Clarke, 2020; Collard and Clarke, 2022). These have shown that the SP/SR exercises can be used to target specific skills around formulation, intervention planning, and for reviewing intervention outcomes. For instance, in the study by Collard and Clarke (2020), participant trainees were asked to develop an exposure intervention for their own social anxiety and to present a situational formulation of their anxiety reaction. Efforts were also made to provide a supportive environment for the exercise, with detailed guidance, an extended time period for completion, and opportunities for trainees to gain additional support if required. Not only did this task allow for an external evaluation of the trainees' formulation skills (which had previously been practised in isolation), it also gave an opportunity to assess their competency in designing and reviewing a behavioural experiment or exposure intervention. The students had previously been informed of the focus on these skills through the provision of learning outcomes and a rubric that highlighted the skills for which they were being assessed, and the related clinical standards required for demonstrating their level of competence with such skills.

Furthermore, from the general reflection prompt on the task it was noted that the task helped the trainees to better appreciate the role of their cognitions in the associated anxiety (formulation skills), to better appreciate the challenge of facing their anxiety during the task (empathy/ interpersonal skills), to appreciate the benefits and limitations of applying coping strategies in the context of such an exercise (intervention skills), and to better appreciate the learning that behavioural challenges can provide (evaluation skills; Collard and Clarke, 2020).

Pairing such exercises with guided reflection, to prompt consideration of related theory and strategies, could then be used to further develop competency in skills related to SP/SR exercise (see Table 1 for examples of questions that could be used in relation to formulation skills, cognitive restructuring exercises, and exposure interventions).

In a training program these could then also be translated into further SP/SR exercises for the trainee, providing an avenue for ongoing observation on the development of such knowledge and skills (e.g. development of competency across a series of exposure interventions with a variety of degrees of challenge, for reinforcement of learning from the exposure exercises, and for generalisation of adaptive learning). Thus, SP/SR can grant the opportunity to work on the

Table 1. Guided questions for competency self-reflection

For formulation exercises:
  What information have I included (e.g. thoughts, feelings, sensations, behaviours)? What may I have omitted?
  Is the formulation congruent? Do the cognitions fit with the emotion? Am I mixing together multiple reactions?
  Have I misrepresented any factors (e.g. mistaking cognitions for emotions)?
  What level of cognitions was I able to attain (automatic thoughts, conditional assumptions/demands, core beliefs)?
  Hypothetically, what other cognitions may have been related to the formulation?
  What types of questions could I have asked to test whether these cognitions were present?
  Have I simply stated the factors that were present, or have I explained how these factors interact to be self-maintaining?
  Are there any other factors contributing to, and potentially complicating, my reaction to the situation (e.g. any meta-cognitive or meta-emotive reactions)?
For cognitive restructuring exercises:
  How much was I able to believe the reframes?
  What stopped me from believing them more?
  Are there any other challenging questions that could have been applied to help break down the maladaptive belief system or to reinforce a new adaptive belief system?
  Did I deliver the restructuring work in a didactic manner or Socratic manner?
  Do I respond better to logical arguments, humour, metaphors, etc?
For exposure/behavioural challenges:
  If I didn't find the task very challenging, how could I increase the level of challenge provided?
  Did I engage in any safety behaviour/unhelpful coping behaviours during the exercise?
  Did I notice any additional thoughts as I went through with the exercise that would be important to include in the formulation for my reaction?
  What did I notice about the interplay between my thoughts, feelings and behaviour as I carried out the exercise?
  If the task was overly challenging, how could the task have been broken down to make it more achievable?
  Are there any coping strategies that may have helped me better engage with the task?
  Are there any other related behavioural challenges that would address the same beliefs?
  How would you design a follow-up exposure intervention to work on generalising or deepening the learning provided from this exercise?

development of competency with skills in a scaffolded manner, rather than under complex scenarios that risk overloading trainees (van Merriënboer and Sluijsmans, 2009).

Such scaffolding of tasks within SP/SR training programs would also allow for a more discrete focus, both in terms of the scenarios under consideration and the area of skill development, reducing the time commitments for trainers/supervisors. As suggest by the research by Schmidt *et al.* (2018), this may provide for a more accurate assessment of competency over more complex training tasks.

Finally, with the focus on self-practice, rather than client practice, the SP/SR framework provides several mechanisms that promote better outcomes for clients. To date, many existing methods for competency assessment in psychology training programs rely on observation of direct client work (Humphreys *et al.*, 2017b). Using a SP/SR approach to training allows for the assessment of a base level of competency prior to engaging with real clients, reducing the potential for trainees delivering ineffective or harmful therapy.

Importantly, training within a SP/SR framework is also suggested to promote outcomes that may also help to address factors in addition to clinical knowledge and technical skill that can negatively impact upon clinical competency. For instance, engagement in SP/SR training has been shown to address factors that may influence a trainee's willingness to implement strategies with a client. This includes the development of confidence in applying specific techniques (Bennett-Levy, 2019; Gale and Schröder, 2014), where a low level of confidence in one's ability may result in avoidance of effective strategies for client problems (Odyniec *et al.*, 2019). It can also address unhelpful attitudes and beliefs about techniques. For instance, negative attitudes about CBT in general or about specific techniques, such as exposure interventions, can reduce the willingness of therapists to apply cognitive behavioural techniques, or at least to apply them in an effective manner (Deacon and Farrell, 2013; Rameswari *et al.*, 2021). Research on SP/SR training strategies

has been shown to have the potential to address such negative beliefs, with participants being more willing and enthusiastic about using the techniques they have practised themselves with their future clients (Bennett-Levy *et al.*, 2003; Collard and Clarke, 2022; Gale and Schröder, 2014).

SP/SR has also been reported to enhance trainees' emotional regulation skills, a competency that has been shown to directly and indirectly influence competence with other skills. For instance, it has been found that trainees undergoing such training generally develop an increased level of self-awareness (Bennett-Levy, 2019; Bennett-Levy and Finlay-Jones, 2018). The awareness of personal processes, including one's worldview, biases, coping strategies, and potential conflicts, is generally considered an important precursor for the ability to provide effective psychological therapy (Pieterse *et al.*, 2013). Increased self-awareness has also been linked to increased acceptance of one's present level of clinical skill (Haarhoff *et al.*, 2011), for enhancing capacity for self-reflective learning (Bennett-Levy *et al.*, 2003), and for preventing burnout (Scott *et al.*, 2021).

Potentially following from this, SP/SR programs are also typically linked to personal development and wellbeing. It has been reported by trainees that it helps with the development of more adaptive beliefs and coping strategies, and with reduced psychological distress (Bennett-Levy, 2019; Gale and Schröder, 2014; McGillivray *et al.*, 2015; Thwaites *et al.*, 2014). The importance of such outcomes is highlighted by research showing that conscientiousness is positively linked to the development of clinical competence while the experience of emotional distress, particularly depression, has been negatively linked to the development of competencies (Humphreys *et al.*, 2017a) and that maladaptive emotion regulation strategies have been linked to compassion fatigue and burnout (Chang and Shin, 2021). Furthermore, SP/SR is suggested to be a method for developing distress tolerance in trainees, a skill required for psychologists, especially when dealing with challenging presentations that may include personality pathology, suicidal or self-injurious behaviour, trauma processing, or exposure interventions (Waltman *et al.*, 2016). Distress tolerance has also been suggested to encourage a willingness to be vulnerable and not perfectionistic and to promote ethical practice, in line with providing the highest quality of client care and an accurate representation of competence (Waltman *et al.*, 2016). Finally, these factors, along with enhanced empathy, may contribute to improved interpersonal skills. This is a commonly reported outcome from SP/SR training, with trainees reporting increased competency in their ability to utilise active listening skills, to explain concepts, to work collaboratively, and to resolve therapeutic rifts that may arise (Bennett-Levy, 2019; Gale and Schröder, 2014; McGillivray *et al.*, 2015).

Taken together, these outcomes suggest that when trainees that progress through a SP/SR program move on to direct client work they have greater self-awareness, are more resilient, and will be equipped with better coping and interpersonal skills. This would subsequently result in better clinical decision making, and thereby improved competency. Again, observation of the development of such competencies could be taken from practices done in a class environment, from recordings, and from written summaries and reflections presented by the trainees, allowing comparison of their skill against established criteria.

Conclusion

Research on training programs for clinical competency have highlighted that the use of problem-based learning and self-practice strategies for promoting a more in-depth and a more nuanced understanding of psychological theory and practices, compared with traditional strategies that have focused on declarative learning. For training in CBT more specifically, use of a SP/SR framework has demonstrated strong outcomes from trainees' self-reports. It also provides a useful framework for scaffolding training programs and the assessment of trainees' competency levels with various clinical skills. The exercises included within such a framework provide an avenue for both the development of understanding and competency with clinical

knowledge and skills. It also provides opportunities for observation and assessment as they practise these on themselves, and for pairing this with guided feedback, which can also help with the development of self-reflective skills.

> **Key practice points**
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> (1) Experiential exercises conducted within a SP/SR framework during training in CBT provides an avenue for competency-based training and assessment.
> (2) Use of experiential exercises within a SP/SR framework allows for scaffolding of skill training prior to trainees engaging in direct client work.
> (3) Use of 'real-plays' in therapist training appears to be superior to the use of role-plays.
> (4) Pairing SP/SR exercises with guided feedback can help with competency development, including competency with self-reflective capacities.

Further reading

Bennett-Levy, J. (2019). Why therapists should walk the talk: the theoretical and empirical case for personal practice in therapist training and professional development. *Journal of Behavior Therapy and Experimental Psychiatry*, *62*, 133–145. https://doi.org/10.1016/j.jbtep.2018.08.004

Bennett-Levy, J., Thwaites, R., Haarhoff, B., & Perry, H. (2015). Experiencing CBT from the inside out: a self-practice/self-reflection workbook for therapists. *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists*. New York, USA: Guilford Press.

Collard, J., & Clarke, M. (2020). Experiential learning for trainee therapists through a shame attack exercise. *Cognitive Behaviour Therapist*, *13*. https://doi.org/10.1017/S1754470X20000549

Fairburn, C. G., & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. *Behaviour Research and Therapy*, *49*, 373–378. https://doi.org/10.1016/j.brat.2011.03.005

References

Beale, S., Liness, S., & Hirsch, C. R. (2020). Trainee self-assessment of cognitive behaviour therapy competence during and after training. *the Cognitive Behaviour Therapist*, *13*. https://doi.org/10.1017/S1754470X19000357

Beck, J. S. (1995). *Cognitive Therapy: Basics and Beyond*. New York: Guilford Press.

Bennett-Levy, J. (2003). Mechanisms of change in cognitive therapy: the case of automatic thought records and behavioural experiments. *Behavioural and Cognitive Psychotherapy*, *31*, 261–277. https://doi.org/10.1017/S1352465803003035

Bennett-Levy, J. (2006). Therapist skills: a cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy*, *34*, 57–78. https://doi.org/10.1017/S1352465805002420

Bennett-Levy, J. (2019). Why therapists should walk the talk: the theoretical and empirical case for personal practice in therapist training and professional development. *Journal of Behavior Therapy and Experimental Psychiatry*, *62*, 133–145. https://doi.org/10.1016/j.jbtep.2018.08.004

Bennett-Levy, J., & Finlay-Jones, A. (2018). The role of personal practice in therapist skill development: a model to guide therapists, educators, supervisors and researchers. *Cognitive Behaviour Therapy*, *47*, 185–205. https://doi.org/10.1080/16506073.2018.1434678

Bennett-Levy, J., Lee, N., Andrews, K., Pohlman, S., Hamernik, E., Travers, K., ... & Hamernik, E. (2003). Cognitive therapy from the inside: enhancing therapist skills through practising what we preach. *Behavioural and Cognitive Psychotherapy*, *31*, 143–158. https://doi.org/10.1017/S1352465803002029

Bennett-Levy, J., & Lee, N. K. (2014). Self-practice and self-reflection in cognitive behaviour therapy training: what factors influence trainees' engagement and experience of benefit? *Behavioural and Cognitive Psychotherapy*, *42*, 48–64. https://doi.org/10.1017/S1352465812000781

Bennett-Levy, J., Thwaites, R., Chaddock, A., & Davis, M. (2009). Reflective practice in cognitive behavioural therapy: the engine of lifelong learning. In *Reflective Practice in Psychotherapy and Counselling* (pp. 115–135). https://doi.org/10.13140/2.1.1111.9040

Bennett-Levy, J., Thwaites, R., Haarhoff, B., & Perry, H. (2015). *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists*. New York, USA: Guilford Press.

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & 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.

Brosan, L., Reynolds, S., & Moore, R. (2008). Self-evaluation of cognitive therapy performance: do therapists know how competent they are? *Behavioural and Cognitive Psychotherapy*, *36*, 581–587. https://doi.org/10.1017/S1352465808004438

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical Psychology Review*, *26*, 17–31. https://doi.org/10.1016/j.cpr.2005.07.003

Chang, J. J., & Shin, S. H. (2021). A path model for burnout in community mental health professionals. *International Journal of Environmental Research and Public Health, 18*. https://doi.org/10.3390/ijerph18189763

Chigwedere, C., Thwaites, R., Fitzmaurice, B., & Donohoe, G. (2019). Self-practice/self-reflection as an alternative to personal training-therapy in cognitive behavioural therapy training: a qualitative analysis. *Clinical Psychology & Psychotherapy*, *26*, 74–83. https://doi.org/doi:10.1002/cpp.2331

Collard, J., & Clarke, M. (2020). Experiential learning for trainee therapists through a shame attack exercise. *Cognitive Behaviour Therapist*, *13*. https://doi.org/10.1017/S1754470X20000549

Collard, J., & Clarke, M. (2022). Use of a low frustration tolerance exercise for trainee therapists in a SP/SR framework. *the Cognitive Behavior Therapist, 15*. https://doi.org/10.1017/S1754470X22000071

Coulson, D., & Harvey, M. (2013). Scaffolding student reflection for experience-based learning: a framework. *Teaching in Higher Education*, *18*, 401–413. https://doi.org/10.1080/13562517.2012.752726

Creed, T. A., Wolk, C. B., Feinberg, B., Evans, A. C., & Beck, A. T. (2016). Beyond the label: relationship between community therapists' self-report of a cognitive behavioral therapy orientation and observed skills. *Administration and Policy in Mental Health and Mental Health Services Research*, *43*, 36–43. https://doi.org/10.1007/s10488-014-0618-5

David, D., & Cristea, I. (2018). The new great psychotherapy debate: scientific integrated psychotherapy vs. plurality. why cognitive-behavior therapy is the gold standard in psychotherapy and a platform for scientific integrated psychotherapy. *Journal of Evidence-Based Psychotherapies*, *18*, 1–18. https://doi.org/10.24193/jebp.2018.2.11

Davis, M. L., Thwaites, R., Freeston, M. H., & Bennett-Levy, J. (2015). A measurable impact of a self-practice/self-reflection programme on the therapeutic skills of experienced cognitive-behavioural therapists. *Clinical Psychology & Psychotherapy*, *22*, 176–184. https://doi.org/doi:10.1002/cpp.1884

Deacon, B. J., & Farrell, N. R. (2013). Therapist barriers to the dissemination of exposure therapy. In *Handbook of Treating Variants and Complications in Anxiety Disorders*. (pp. 363–373). New York: Springer Science + Business Media. https://doi.org/10.1007/978-1-4614-6458-7_23

Dunning, D., Johnson, K., Ehrlinger, J., & Kruger, J. (2003). Why people fail to recognize their own incompetence. *Current Directions in Psychological Science*, *12*, 83–87. https://doi.org/10.1111/1467-8721.01235

Dunsmuir, S., Frederickson, N., & Lang, J. (2017). Meeting current challenges in school psychology training: the role of problem-based learning. *School Psychology Review*, *46*, 395–407. https://doi.org/10.17105/SPR-2016-0017.V46-4

Fairburn, C. G., & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. *Behaviour Research and Therapy*, *49*, 373–378. https://doi.org/10.1016/j.brat.2011.03.005

Gale, C., & Schröder, T. (2014). Experiences of self-practice/self-reflection in cognitive behavioural therapy: a meta-synthesis of qualitative studies. *Psychology and Psychotherapy: Theory, Research and Practice*, *87*, 373–392. https://doi.org/doi:10.1111/papt.12026

Haarhoff, B., Gibson, K., & Flett, R. (2011). Improving the quality of cognitive behaviour therapy case conceptualization: the role of self-practice/self-reflection. *Behavioural and Cognitive Psychotherapy*, *39*, 323–339. https://doi.org/10.1017/S1352465810000871

Humphreys, L., Crino, R., & Wilson, I. (2017a). Psychological functioning predicts competence development for postgraduate students of professional psychology. *Training and Education in Professional Psychology*, *11*, 49–56. https://doi.org/10.1037/tep0000139

Humphreys, L., Crino, R., Wilson, I., & Hannan, T. (2017b). A preliminary analysis of a competence assessment tool for postgraduate training programmes in clinical and forensic psychology. *Clinical Psychologist*, *21*, 165–173. https://doi.org/10.1111/cp.12080

Kaslow, N. J., Grus, C. L., Campbell, L. F., Fouad, N. A., Hatcher, R. L., & Rodolfa, E. R. (2009). Competency assessment toolkit for professional psychology. *Training and Education in Professional Psychology, 3*. https://doi.org/10.1037/a0015833

Kruger, J., & Dunning, D. (1999). Unskilled and unaware of it: how difficulties in recognizing one's own incompetence lead to inflated self-assessments. *Journal of Personality and Social Psychology*, 77, 1121–1134. https://doi.org/10.1037/0022-3514.77.6.1121

Kuyken, W., Fothergill, C. D., Musa, M., & Chadwick, P. (2005). The reliability and quality of cognitive case formulation. *Behaviour Research and Therapy*, 43, 1187–1201. https://doi.org/10.1016/j.brat.2004.08.007

Lertora, I. M., Croffie, A., Dorn-Medeiros, C., & Christensen, J. (2020). Using relational cultural theory as a pedagogical approach for counselor education. *Journal of Creativity in Mental Health*, 15, 265–276. https://doi.org/10.1080/15401383.2019.1687059

Liness, S., Beale, S., Lea, S., Byrne, S., Hirsch, C. R., & Clark, D. M. (2019a). Evaluating CBT clinical competence with standardised role plays and patient therapy sessions. *Cognitive Therapy and Research*, 43, 959–970. https://doi.org/10.1007/s10608-019-10024-z

Liness, S., Beale, S., Lea, S., Byrne, S., Hirsch, C. R., & Clark, D. M. (2019b). Multi-professional IAPT CBT training: clinical competence and patient outcomes. *Behavioural and Cognitive Psychotherapy*, 47, 672–685. https://doi.org/10.1017/S1352465819000201

Liness, S., & Muston, J. (2022). *National curriculum for High Intensity Cognitive Behavioural Therapy courses* (4th edn). UK: Department of Health.

McGillivray, J., Gurtman, C., Boganin, C., & Sheen, J. (2015). Self-practice and self-reflection in training of psychological interventions and therapist skills development: a qualitative meta-synthesis review. *Australian Psychologist*, 50, 434–444. https://doi.org/10.1111/ap.12158

McManus, F., Rakovshik, S., Kennerley, H., Fennell, M., & Westbrook, D. (2012). An investigation of the accuracy of therapists' self-assessment of cognitive-behaviour therapy skills. *British Journal of Clinical Psychology*, 51, 292–306. https://doi.org/10.1111/j.2044-8260.2011.02028.x

Nemec, P. B., Swarbrick, M., & Legere, L. (2015). Prejudice and discrimination from mental health service providers. *Psychiatric Rehabilitation Journal*, 38, 203–206. https://doi.org/10.1037/prj0000148

Odyniec, P., Probst, T., Margraf, J., & Willutzki, U. (2019). Psychotherapist trainees' professional self-doubt and negative personal reaction: changes during cognitive behavioral therapy and association with patient progress. *Psychotherapy Research*, 29, 123–138. https://doi.org/10.1080/10503307.2017.1315464

Pachana, N. A., Sofronoff, K., Scott, T., & Helmes, E. (2011). Attainment of competencies in clinical psychology training: ways forward in the Australian context. *Australian Psychologist*, 46, 67–76. https://doi.org/10.1111/j.1742-9544.2011.00029.x

Padesky, C. A. (1996). Developing cognitive therapist competency: teaching and supervision models. In P. M. Salkovskis (ed), *Frontiers of Cognitive Therapy* (pp. 266–292). New York: Guilford Press.

Pieterse, A. L., Lee, M., Ritmeester, A., & Collins, N. M. (2013). Towards a model of self-awareness development for counselling and psychotherapy training. *Counselling Psychology Quarterly*, 26, 190–207. https://doi.org/10.1080/09515070.2013.793451

Rameswari, T., Hayes, B., & Perera-Delcourt, R. (2021). Measuring therapist cognitions contributing to therapist drift: a qualitative study. *the Cognitive Behaviour Therapist, 14*. https://doi.org/10.1017/S1754470X21000039

Rozek, D. C., Serrano, J. L., Marriott, B. R., Scott, K. S., Hickman, L. B., Brothers, B. M., . . . Simons, A. D. (2018). Cognitive behavioural therapy competency: pilot data from a comparison of multiple perspectives. *Behavioural & Cognitive Psychotherapy*, 46, 244–250. Retrieved from http://10.0.3.249/S1352465817000662

Schmidt, I. D., Strunk, D. R., Derubeis, R. J., Conklin, L. R., & Braun, J. D. (2018). Revisiting how we assess therapist competence in cognitive therapy. *Cognitive Therapy and Research*, 42, 369–384. https://doi.org/10.1007/s10608-018-9908-7

Scott, J., Yap, K., Bunch, K., Haarhoff, B., Perry, H., & Bennett-Levy, J. (2021). Should personal practice be part of cognitive behaviour therapy training? Results from two self-practice/self-reflection cohort control pilot studies. *Clinical Psychology and Psychotherapy*, 28, 150–158. https://doi.org/10.1002/cpp.2497

Spendelow, J. S., & Butler, L. J. (2016). Reported positive and negative outcomes associated with a self-practice/self-reflection cognitive-behavioural therapy exercise for CBT trainees. *Psychotherapy Research*, 26, 602–611. https://doi.org/10.1080/10503307.2015.1058983

Stoltenberg, C. D., & Pace, T. M. (2007). The scientist-practitioner model: now more than ever. *Journal of Contemporary Psychotherapy*, 37, 195–203. https://doi.org/10.1007/s10879-007-9054-0

Taylor, D. C. M., & Hamdy, H. (2013). Adult learning theories: Implications for learning and teaching in medical education: AMEE Guide No. 83. *Medical Teacher, 35*. https://doi.org/10.3109/0142159X.2013.828153

Thwaites, R., Bennett-Levy, J., Cairns, L., Lowrie, R., Robinson, A., Haarhoff, B., . . . & Perry, H. (2017). Self-practice/self-reflection (SP/SR) as a training strategy to enhance therapeutic empathy in low intensity CBT practitioners. *New Zealand Journal of Psychology*, 46, 63–70.

Thwaites, R., Bennett-Levy, J., Davis, M., & Chaddock, A. (2014). Using self-practice and self-reflection (SP/SR) to enhance CBT competence and meta-competence. In Whittington, A., & Grey, N. (eds), *How to Become a More Effective CBT Therapist: Mastering Metacompetence in Clinical Practice* (pp. 241–254). Wiley-Blackwell.

Trinidad, A. C. (2007). How not to learn cognitive-behavioral therapy (CBT). *American Journal of Psychotherapy*, *61*, 395–403. Retrieved from: http://ezproxy.deakin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true& db=psyh&AN=2008-11375-003&site=ehost-live&scope=site

Trope, Y., & Liberman, N. (2010). Construal-level theory of psychological distance. *Psychological Review*, *117*, 440–463. https://doi.org/10.1037/a0018963

van Merriënboer, J. J. G., & Sluijsmans, D. M. A. (2009). Toward a synthesis of cognitive load theory, four-component instructional design, and self-directed learning. *Educational Psychology Review*, *21*, 55–66. https://doi.org/https://doi.org/10.1007/s10648-008-9092-5

von Treuer, K. M., & Reynolds, N. (2017). A competency model of psychology practice: articulating complex skills and practices. *Frontiers in Education*, *2*, 1–7. https://doi.org/10.3389/feduc.2017.00054

Waltman, S. H., Frankel, S. A., & Williston, M. A. (2016). Improving clinician self-awareness and increasing accurate representation of clinical competencies. *Practice Innovations*, *1*, 178–188. https://doi.org/10.1037/pri0000026

Wiggins, S., Chiriac, E. H., Abbad, G. L., Pauli, R., & Worrell, M. (2016). Ask not only 'what can problem-based learning do for psychology?' but 'what can psychology do for problem-based learning?' A review of the relevance of problem-based learning for psychology teaching and research. *Psychology Learning and Teaching*, *15*, 136–154. https://doi.org/10.1177/1475725716643270