The Cognitive Behaviour Therapist (2018), vol. 11, e5, page 1 of 19
doi:10.1017/S1754470X1800003X

ORIGINAL RESEARCH

How beginning cognitive behavioural therapists develop professional confidence

Lenka Maruniakova* **and Tomas Rihacek**

Department of Psychology, Masaryk University, Brno, Czech Republic

Received 5 September 2017; Accepted 9 March 2018

Abstract. Evidence exists that the effectiveness of psychotherapy depends more on therapists' variables than on their theoretical orientation or the techniques they use. Nevertheless, relatively little is known regarding the process of cognitive behavioural psychotherapists' development. The purpose of the study was to explore how beginning cognitive behavioural therapy (CBT) practitioners develop, considering various professional and personal influences. Eight in-depth interviews with beginning therapists were conducted, and the Grounded Theory Method was used for data analysis. The developmental process was conceptualized as Gaining Professional Confidence, and three phases of this process were identified: (1) Externally Based Confidence in CBT Methods, (2) Internalized Confidence in CBT Methods, and (3) Therapists' Self-Confidence. The results indicate that trainees' self-reflection on their personal qualities, values, attitudes and preferences should be given more attention in CBT training, as this plays a crucial role in their overall professional development.

Key words: cognitive behavioural therapy training, professional and personal sources in therapist development, therapist confidence, professional identity, grounded theory method

Introduction

Over the past two decades, there has been increasing interest in psychotherapists' professional development as opposed to examining treatments and their effectiveness. This shift of research focus was encouraged by research studies demonstrating that psychotherapists differ in their outcomes and that the effectiveness of psychotherapy depends more on therapists' variables than on their theoretical orientation or the techniques they employ (for a review, see e.g. Baldwin and Imel, 2013; Wampold and Imel, 2015). It has been argued that rather than adhering strictly to a cognitive behavioural (or any other) protocol, psychotherapists tend to work from their own personal styles (Rihacek and Roubal, 2017), which may account for their differential effectiveness. However, there are only a few empirical studies on the professional development of beginning cognitive behavioural therapists. The majority of these studies

*Author for correspondence: Lenka Maruniakova, Department of Psychology, Faculty of Social Studies, Masaryk University, Jostova 10, 602 00 Brno, Czech Republic (email: maruniakova.lenka@gmail.com)

sought to evaluate cognitive behavioural therapy (CBT) training, supervision effectiveness and clients' outcomes (Milne *et al*., 1999; McManus *et al*., 2010; Rakovshik and McManus, 2010; Reiser and Milne, 2012). Several studies demonstrated that during CBT training, therapists developed their professional competences (e.g. the ability to conceptualize, create a treatment plan, and use appropriate techniques) and increased their use of CBT techniques in their practice (e.g. Barnfield *et al*., 2007; Freiheit and Overholser, 1997; James *et al*., 2001; Myles and Milne, 2004).

A key study exploring trainees' perspective on gaining CBT competence during a 1-year part-time training programme was conducted by Bennett-Levy and Beedie (2007). Their results showed that trainees perceived significant increase in their professional competence. However, a variation between individuals and across different skills was identified. Based on their qualitative data, the authors developed a model describing the main influences on perceived competence by trainees. The major components of trainees' self-perception of competence were the learning opportunities experienced by the participant (e.g. experience with clients, external evaluation from supervisors, peers and clients, trying out new intervention, reading, etc.), self-reflection on performance, increased awareness of the standards required of a cognitive therapist and trainees' emotional state.

Furthermore, Wolff and Auckenthaler (2014) investigated the development of CBT trainees' theoretical orientation and described it as an active and complex process. Trainees, who were perceived as 'constructing jugglers', developed coherent theoretical orientations by employing various strategies, constantly defining and redefining CBT and other approaches. If we are to understand how trainees actually benefit professionally from a CBT training programme, further exploration of this process might be the next step in this research field.

Several studies revealed the importance of professional and personal formative influences in the development of psychotherapists. In Rønnestad and Skovholt's (2003) study, the most influential sources included interaction with clients, supervision, personal therapy, and personal life. Similarly, in their survey of a group of qualified psychotherapists and clinical psychologists in training, Lucock *et al*. (2006) found that both groups rated the following factors as most influential: supervision, client characteristics, client feedback, psychological formulation, and professional training. Evidence-based guidelines, conversely, were ranked relatively low for both groups although the CBT therapists rated them somewhat higher than therapists of other orientations. These findings do not appear to correspond well with training practice in CBT, in which great emphasis is traditionally given to manuals and guidelines to the exclusion of other sources such as one's personal life or therapists' characteristics (Barnfield *et al*., 2007; Haarhoff *et al*., 2011; Muse and McManus, 2013; Rakovshik and McManus, 2010).

Training techniques such as didactic lectures, literature reading, clinical case demonstrations, behavioural role-play and supervision have been demonstrated to be effective CBT training methods for professional competency development (Bennett-Levy *et al*., 2009a; Sudak, 2009). However, reflection has been seen as key to therapist knowledge and skill development (e.g. Bennett-Levy, 2006; Bennett-Levy *et al*., 2009b; Skovholt and Ronnestad, 1992). There has been increasing research into the implementation of experiential and reflective practice into the CBT training programmes, known as the concept of self-practice/self-reflection (SP/SR), which has appeared to be a valuable training tool for both the personal and professional development of CBT therapists (Beidas and Kendall, 2010; Bennett-Levy and Lee, 2014; Bennett-Levy *et al*., 2003; Farrand *et al*., 2010; Haarhoff

et al., 2011; Laireiter and Willutzki, 2003). At the professional level, SP/SR was connected with increased understanding of CBT perspectives and methods, confidence enhancement, CBT skills development and reflective abilities. At the personal level, trainees improved in self-awareness and comprehension of personal processes (Bennett-Levy and Beedie, 2007; Bennett-Levy and Lee, 2014; Bennett-Levy *et al*., 2003; Farrand *et al*., 2010; Haarhoff *et al*., 2011).

Beginning therapists enter the professional field with little or no professional experience. Therefore, beginners experience high levels of anxiety and self-doubt and a sense of incompetence (Bischoff, 1997; Hill *et al*., 2007; Schwing *et al*., 2011; Skovholt and Rønnestad, 2003). Easily acquired and straightforward methods ideally applicable to all clients and their problems are 'life-savers' for beginners (Rønnestad and Skovholt, 2003). Following prescribed methods and principles may provide beginning therapists with guidance and reassurance and facilitate their entry into the field of practice. On the other hand, the tendency towards a rigid adherence to a therapeutic model, which is typical for a beginner's phase (Hill *et al*., 1981, 2007; Skovholt and Rønnestad, 1992), may prevent trainees from an authentic connection to and comprehension of their clients, and may lead to an inflexible use of techniques (Hatcher and Lassiter, 2007; Sharpless and Barber, 2009). Therefore, it is essential to understand trainees' needs and learning processes at various stages of development to reduce the risk of the potentially negative effects of psychotherapy manuals. The interest in the therapeutic relationship and its role in the treatment has increased in the past two decades among CBT therapists. A few studies showed the importance of the therapeutic relationship in CBT for the therapy outcome (see Leahy, 2008, for a review). A challenge for beginning CBT therapists then might arise from following the CBT methodology and simultaneously focusing on ongoing improvement of the therapeutic relationship.

Previous research suggests that trainees improve their CBT skills; however, the very process of skills development, as well as trainee development in a broader sense, deserves more attention. Therefore, the purpose of this study was to explore how beginning cognitive behavioural therapists perceive their development and what professional and personal influences they consider as important for their therapeutic practice. As such, the aim of this study was to explore the subjective experience of beginning CBT therapists and their views on adopting and applying CBT methods. Given the exploratory nature of the research goal, the Grounded Theory Method (GTM) was chosen as a methodological framework that allows researchers to develop a theory of a phenomenon inductively (Charmaz, 2006; Glaser and Strauss, 1967).

Method

Participants

Eight Czech beginning CBT therapists (five women and three men), aged 25 to 36 years, participated in this study. Their training level ranged from the third year of training to 2 years after training. For all of them, CBT training was their first psychotherapy training. Their length of practice ranged from 9 months to 7 years, and their overall number of clients varied from five to 100. The key attributes defining participants as beginners were the following: (a) current participation in a CBT training programme or maximum 3 years after completing the programme; and (b) perceiving oneself as a beginner. Four participants

Table 1. *Participants' characteristics*

Nickname	Age	Profession	Year of training	Length of practice	Overall number of clients
Jane	26	Psychologist	3rd year	9 months	5
Beth	30	Psychologist	5th year	1 year	15
Patricia	28	Nurse	Finished 2 years ago	7 years	Approx. 100
Cathy	32	Psychiatrist	Finished 2 years ago	4 years	35
Rachel	31	Psychologist	3rd year	2 years	30
Tim	25	Psychologist	4th year	3 years	80
Matt	28	Psychologist	3rd year	3 years	25
Hank	36	Psychologist	4th year	5 years	98

had been in counselling or clinical practice before entering the CBT training (as they already held a professional degree in psychology and psychiatry[1]), and four began their clinical practice during the CBT training. By calling our participants 'CBT therapists' we do not necessarily imply that they adhere to the CBT method completely in their practice. We simply refer to the fact that they are trainees/fresh graduates of a CBT training. Fictional names are used throughout the text to ensure participants' anonymity (see Table 1 for participants' characteristics).

Participants were recruited from two CBT training institutes. Both training institutes were private organizations providing part-time psychotherapy training, which is typical for psychotherapy training in the Czech Republic. The training programme was in accordance with standards of the European Association for Behavioural and Cognitive Therapies (EABCT) and accredited by the Czech Psychotherapeutic Society. The 5-year training programme consisted of: 120 hours of theoretical lectures, 350 hours of personal practice with CBT (i.e. application of CBT methods on oneself and other trainees in small group workshops, role-plays), 100 hours of supervision provided by an internal lecturer of the training programme and 25 hours of supervision with an external supervisor. The 3- or 5-day training sessions took place five times per year. Lectures and supervision were provided by leading Czech CBT therapists. Trainees were regularly given homework and assignments which consisted mostly of reading and essays on particular topics. Trainees were also required to present a certain number of CBT cases from their own practices and at the end of the training programme they had to pass an exam that consisted of a theoretical and practical part, and a final thesis defence. Entry requirements to the training included a BA or MA degree in psychology or another helping profession (e.g. psychiatry, nursing care, or social work).

Design

The participants were required to meet three criteria for inclusion: (1) being in CBT training or having completed CBT training no more than 3 years previously, (2) CBT training being their first and only systematic psychotherapy training so far, and (3) being actively involved in clin-

[1]These participants mentioned that previous experience as a counsellor or a psychiatrist had provided them with basic clinical comprehension and skills they tended to utilize later in their clinical practice.

ical practice. We deliberately recruited therapists in advanced stages of their training as well as those who had recently completed their training to capture the dynamics of professional development during this period. Potential participants were approached by a combination of an email sent by training institute representatives and personal contacts of the first author.

The data collection was initially guided by the main research question 'How do beginning CBT therapists develop?'. Both researchers are trained in a humanistic theoretical orientation and have no particular expertise in CBT. In their approach to the phenomenon, they were influenced by the concept of Personal Therapeutic Approach – an idea that psychotherapists tend to develop their own, idiosyncratic approaches which include meta-theoretical assumptions, theoretical concepts, repertoire of techniques, relational aspects, and professional identity. These approaches evolve within the interaction of psychotherapists' personal characteristics and life experiences, as well as their professional training and clinical experience throughout their careers (Rihacek and Roubal, 2017). This concept provided a basis for the researchers' pre-existing understanding of the process of psychotherapist professional development.

The first author conducted a semi-structured in-depth interview with each participant. Prior to the interview, the first author sent the participants a list of four questions to stimulate their reflection on their own professional development and provide them enough time for such a reflection. The questions were as follows: (1) What in your life was, or is, important for your practice?; (2) In which way were these aspects important for your practice?; (3) Can you give any examples of how you work with a client in compliance with the CBT approach?; and (4) Have you ever had a client for whom the CBT approach was not appropriate? If so, how did you conduct the therapy?

Following the principles of GTM, our preconceptions arising from our previous research and from our basic knowledge of CBT methodology and training were intentionally bracketed in order to both reduce biases resulting from these preconceptions and to maximize our openness to any kind of data. Therefore, the primary questions were set broadly to allow participants to reflect upon their own genuine experience and come up with their own understanding of their developmental process. For example, we did not open the interview with a question about the CBT training specifically as we kept the possibility that there might have been other important influences for participants' development and their practice. The interview started with the first question. During the interview participants were encouraged to comment on all sources while also being asked questions 2, 3 and 4 to ensure the flow of the dialogue. The emphasis was placed on exploring what participants considered as a formative influence. The interviews lasted from 90 to 120 minutes. Each interview was immediately transcribed and analysed, and the interim results were used to guide subsequent interviews (Charmaz, 2006).

Data analysis

The analysis followed the principles of the GTM (Charmaz, 2006; Glaser and Strauss, 1967), which is based on an inductive creation of categories grounded in the data. By the process of constant comparison, researchers conceptualized these emerging categories and their relations. We adhered to Charmaz's (2006) constructivist reformulation of the method, reflecting that the resultant theory is not meant to be an accurate description of reality, but a researcher's construction rigorously developed from data. By explicating our theoretical

orientations and research background, we also admitted that a researcher of a dissimilar theoretical perspective may have conceptualized the results differently. However, having a different theoretical perspective was considered as an asset during the interviews for two reasons: (a) it allowed the researchers to investigate participants' experience without having presumptions and/or expectations how CBT should be provided according to the guidelines, and (b) being interviewed by a researcher with a non-CBT background enabled participants to speak freely and openly about the nature of their work without fear of being judged or criticized for not strictly adhering to CBT methodology.

The analysis progressed in following stages: first, a preliminary analysis of each interview was conducted parallel to data collection by the first author and discussed regularly with the second author. Throughout this process, a phenomenon of developing therapists' self-confidence started to emerge as a core process underlying the participants' professional development. Participants' narrations contained excerpts describing, both explicitly and implicitly, the process of gaining trust in CBT and eventually in themselves. Therefore, the category of Gaining Professional Confidence was determined to be the most salient category in the analysis and later became the central category of the emergent theory. Second, all interviews were re-analysed in relation to this central category by the first author, and the process was again thoroughly discussed with the second author. During this procedure, the central category was elaborated upon and connected with other categories to form a three-phase model. Each phase was formulated in terms of its sources (i.e. the conditions and events that precipitated the onset of the given phase) and consequences (i.e. the effects the developmental movement had on the participants). This step was part of a theoretical coding process within which categories were organized into 'theoretically meaningful' relationships (e.g. hierarchical, cause–effect, or goals–means relationships) in order to formulate a theory of the phenomenon that fits the data (Glaser, 1978). Third, after the model was formulated, the first author checked its groundedness in the data by closely examining all interviews again. At this stage, the resultant model was adjusted to account for all cases.

Results

Gaining Professional Confidence

Using the GTM, we framed the developmental process of beginning CBT therapists as Gaining Professional Confidence. This process was conceptualized into three phases: (1) Externally Based Confidence in CBT (i.e. confidence based on the perceived benefits of CBT and its research-proven effectiveness), (2) Internalized Confidence in CBT (i.e. confidence based on therapists' own experiences with the positive effects of CBT methods), and (3) Therapists' Self-Confidence (i.e. confidence based on therapists' own proficiency and resources). Each phase was characterized by specific sources of confidence (i.e. what supported participants in gaining that particular confidence during their development) and consequences it had for therapists' practice (see Fig. 1). The phases will be presented as successive to provide the understanding of the developmental process. However, in reality, they tended to overlap: while reaching the stage of Therapists' Self-Confidence in a particular area (e.g. treating mental eating disorders), there were other areas where participants still based their work on confidence in CBT guidelines solely.

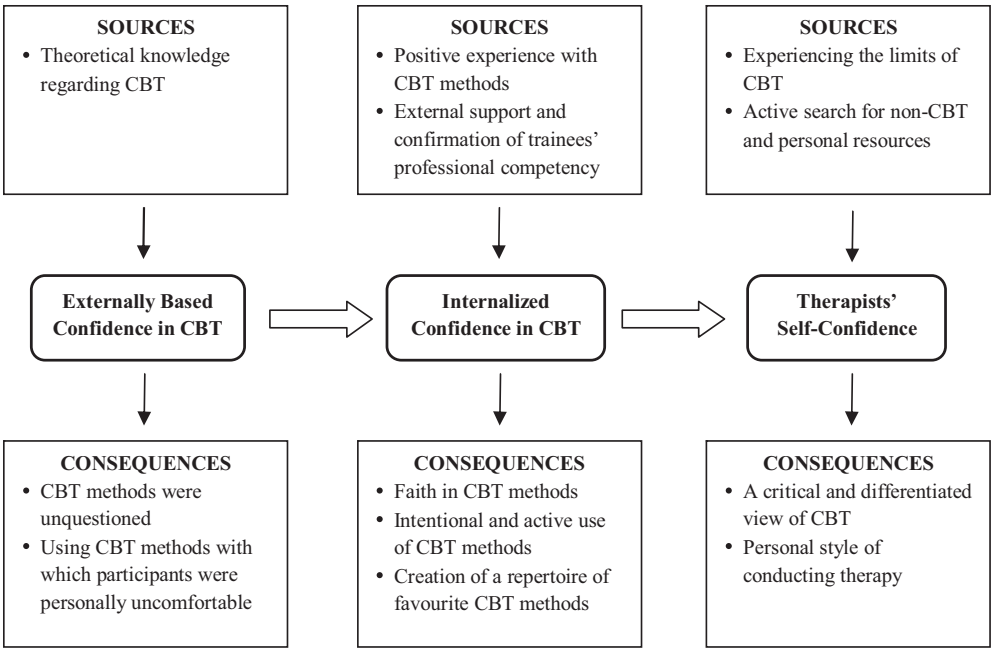

Figure 1. The process of Gaining Professional Confidence

Externally Based Confidence in CBT: 'I believe CBT works because I was told so'

Before entering the training and at the beginning of the CBT training, participants lacked practical experience with CBT and had not had opportunities to examine CBT methods with clients. Rather, their faith in CBT was based on information on CBT they had gathered from experts, theoretical literature and research. These external resources gave credibility to the CBT approach and motivated participants in their studies.

Sources

Theoretical knowledge regarding CBT

For the majority of the participants, their confidence in CBT was established long before entering the training and was strengthened as their theoretical knowledge increased. This information came from CBT-oriented lecturers and trainers, theoretical literature, manuals and the empirical studies they encountered during their MA study programmes. The very existence of extensive CBT literature was perceived as a confirmation of the credibility and applicability of the approach: '*I say to myself that those people who created and provide CBT were not stupid at all and I can rely on them*' (Jane). Furthermore, trainers' enthusiasm and their personal testimonies of CBT effectiveness rendered the approach attractive to students.

The participants appreciated attributes such as the intelligibility, rationality, logicality, clear evidence-based manuals and therapy structure, wide scale of applications, and instant applicability of the CBT methods. Such attributes also offered participants a solid structure

for their work from the very beginning, which helped them decrease their anxiety and self-doubts as they felt equipped with tangible resources.

The participants often emphasized the match between their own personal characteristics and perceived CBT attributes before enrolling in the CBT training, for example, a personal need for evidence and measurable client outcomes (Matt). On the other hand, some participants entered the training to acquire skills, typical to a CBT approach, they lacked. For example, Tim aimed to learn how to maintain the structure of a therapy session and focus on solutions.

Consequences

CBT methods were unquestioned

Because of the strong confidence in CBT methods and their efficacy, participants tended to attribute failures either to themselves or to their clients, but not to the method:

> *It is the advantage of CBT that so many people have tested it before and verified it so that it's either something in the client, or in me, not in the method or technique itself; it's about how they are used in practice. The techniques are basically not wrong* (Jane).

Using CBT methods with which participants were personally uncomfortable

Although some participants were uncomfortable or had an unsatisfactory experience with a technique, or even feared some of the complex CBT techniques, they continued using that technique with clients because they believed in it or had observed in the training programme its usefulness for other people: '*Relaxation doesn't suit me personally, but it does suit my clients, so I use it in practice*' (Rachel).

However, two participants with more professional experience (Hank and Tim) did not feel an obligation to strictly adhere to CBT methods and felt more independent of the training prescriptions.

Internalized Confidence in CBT: 'I know it works because I have examined CBT methods myself.'

Ongoing clinical practice allowed the participants to personally verify the anticipated effects of CBT methods and thus develop confidence in those methods. However, this internalized sense of confidence developed only gradually because the participants had to go through this process every time they attempted to implement a new technique. Therefore, their overall approach to CBT remained a mixture of internalized confidence and the external support and reassurance provided by their trainers and supervisors.

Sources

Positive experience with CBT methods

The participants had opportunities to examine CBT methods in different settings, including self-practice (i.e. applying CBT techniques to themselves), role-play in training (i.e. applying CBT techniques on the training peers), and therapy with real clients. Through these experiences, participants learned about their own responses to these techniques and explored

their effects with multiple real or role-play clients. After learning a new CBT method, participants demonstrated zeal and an effort to use this approach in therapy. Jane commented on this process:

> *These role-plays are good because you somehow gradually gain confidence in the therapist's role. (. . .) such a practical thing when practising cognitive restructuring. I have already practised it so many times and I've done it so many times for homework that I know what I should ask my clients.*

Repeated experience with CBT techniques also helped the participants appreciate the theory behind these techniques and understand why an intervention is conducted in a particular sequence of steps.

External support and confirmation of trainees' professional competency

The participants still felt a strong need for encouragement and approval, which was provided not only by trainers and supervisors but also by co-trainees, other CBT practitioners (such as colleagues and friends) and therapeutic manuals. In particular, the trainees sought counsel when they (a) required reassurance regarding the right course of therapy, (b) needed to formulate a treatment plan or gain inspiration, and (c) needed to review their theoretical knowledge. At this stage, the participants appreciated CBT manuals as easily accessible sources of assurance and guidance.

> *I also got into a situation where I did not know what to do, but it's very conceptual and gives me the support to avoid a situation where I really do not know what to do. Obviously, there is uncertainty; I feel uncertainty in every session, but it* [a CBT manual] *gives me a foothold on what to do, what to do next, or what to use, where to go further with the patient* (Matt).

Supervisors and other CBT experts played a key role at this stage in helping participants to connect their practical experience with the CBT framework and in mentoring them on which CBT methods could have been applied in that particular case and how. Such feedback helped participants to reflect on what did not work in the session and why and, also, to set a benchmark for evaluating their work on their own. Besides that, the supervisors were also a source of emotional support which motivated participants to persist despite the struggles and challenges. Beth, for example, felt relieved when her supervisor kept guiding her with patience and kindness despite bringing up the same problem she had already discussed before.

Consequences

Faith in CBT methods

At the cognitive level, participants demonstrated internal conviction regarding the positive effects of CBT and the necessity to use CBT methods to cope with clients' problems. Matt, for example, explained why he believed that the use of exposure was necessary when treating a client with a phobia:

> *The point of using a CBT technique is that I will not talk about it for four sessions because I really believe in, and, in fact, I identify myself with it, that to get rid of a phobia I must expose myself to it. And I fear spiders. I have a problem with that, but I really believe in this. (...) Because if you have a fear of spiders and you will just talk about it for four months, it will not lead anywhere.*

Intentional and active use of CBT methods

Consequently, the participants began to use CBT techniques on a regular basis – not only in their practice but also in their personal lives. CBT methods thus became inseparable components of their working style. When participants encountered a problem they had successfully solved in the past, they tended to use the same method again to ensure a positive outcome. Tim, for example, reported how the behavioural analysis became a core tool in his therapeutic repertoire:

> *I somehow accepted it personally. It is important to me not only being empathetic to the client and just trying different things, but simply to understand and analyse the functionality of his behaviour. … I put a great emphasis on understanding the function of the symptoms.*

Creation of a repertoire of favourite CBT methods

The participants naturally tended to prefer some of the CBT methods to others and to develop a repertoire of 'pet' interventions. Hank gave an example of his favourite techniques:

> *Cognitive restructuring is my favourite technique through which a patient may think about the problem in a different way and decrease the catastrophic feelings and thoughts. There's the work with automatic thought, which is also my favourite technique that I use when I get stuck or when a patient is ready to use it. … So I have my favourite techniques.*

Therapists' Self-Confidence: 'I can rely on myself because I know I have sources for dealing with a variety of clients' problems.'

With growing professional experience and successful applications of the CBT approach, the participants began to feel more confident in the therapist role. They also reflected on clients' real needs during the sessions and those became the most important determinants in what they did in their practice. Consequently, they began to evaluate their practices more from their own perspectives rather than adhering to what they perceived as 'a pure-form CBT'. This shift in perspective allowed the participants to realize some limitations or negative effects of CBT interventions and to incorporate interventions from other psychotherapy traditions that they considered more appropriate for some clients. Two participants who already possessed considerable professional experience at the beginning of their CBT training reported they never truly adhered to CBT and had considered themselves integrationists from the beginning of their training.

Sources

Experiencing the limits of CBT

Sometimes, techniques that were easy and smooth to perform in a training setting were deemed difficult to implement in real practice, did not bring the expected outcome, or were perceived as hindering the psychotherapy process. The participants were then confronted with feelings of incompetence and uncertainty and began to realize the limits of CBT. Rachel gave an example of such a situation:

> [A] *child comes and says, 'My mother does not care about me. My stepfather trashes me, he thrashes my mother and she does not want to leave because she is dependent on him because of the money. And I miss my father, who died eight years ago, and I talk to him every day.' Then, I have a problem using the CBT methods we learnt.*

Active search for non-CBT and personal resources

To compensate for the limits of the CBT approach, the participants began to search for other resources. They experimented with non-CBT techniques and concepts (e.g. circular questioning from systemic therapy or chair work from Gestalt therapy) when they became stuck with their clients or when they wanted to approach a client's issue from another perspective. However, the CBT framework the participants had developed in training was still perceived and utilized as a stable base to which they could return any time and within which they could integrate these new elements. Non-CBT resources often helped participants prepare their clients for a particular CBT technique. In the following example, Cathy described that adding a new perspective enabled her to identify critical issues related to her client's problem:

> *Sometimes, it's all connected. Usually, you need to look for any further issues that seem to be way off. With this patient, whose contract is to act assertively, I'm exploring her relationships with her mother and her brother. This is such a crucial topic for her. (...) I think I'm bringing psychoanalysis to it. I don't think it's too much. But I am affected by it, definitely.*

The participants also drew on skills and knowledge they had acquired outside their CBT training. These included, for example, refined communication skills and awareness of the centrality of the therapeutic relationship (which contrasted with their view of CBT as a rather technical approach). The participants also built on their own experiences that had formed their personal attitudes and beliefs regarding what is essential in therapy and that were in some cases more determinative than CBT recommendations. These personal experiences (e.g. death of a family member, anxiety disorder, or anorexia) also allowed them to empathize with their clients and occasionally use self-disclosure.

Consequences

A critical and differentiated view of CBT

The participants began to view CBT in a more differentiated manner: they endorsed some aspects while dismissing others. Cathy, for example, reflected on the fact that a CBT technique failed to help her in a state of strong emotions. Furthermore, she was convinced that another CBT technique was too shallow to produce a lasting change in clients:

> *I thought that maybe Socratic questioning leads to pushing people to the corner. That's nonsense. In some cases, it may be good, but I don't want to do it against the grain. (. . .) At that moment,* [the client] *might say: 'It's silly', but when he goes home, he falls again into the deep. I find it superficial.*

To help their clients, the participants tended to modify the therapy according to what they thought was the best approach for a particular client. For example, Jane described how she worked with a new client who was unable to define her problem:

We're gradually getting to the problem. And it seems to me that it is not easy for her to say it out loud. Whenever we come to it, it's emotionally demanding for her. She tends to avoid it when we get to that. If I really wanted her to define the problem at that point, she would have avoided it again or would have selected another problem, as she had already done before. (...) And I think, with this client, it is very important to develop a relationship first, rather than to define a problem to be solved.

Personal style of conducting therapy

As a response to the variability of clients, their real needs, and diagnosis on one hand and their personal qualities and preferences on the other, the participants tended to create their personal working styles. Thus, an aspect of individual creativity and integration with other professional methods was apparent:

I don't do pure CBT… I've always modified it (…), and eventually I add something else. (…) I don't work strictly according to the CBT structure; I add what I learned from other experts – some of my questions are more dynamic (…) I adjust it to my own needs and for my own style of work (Hank).

Discussion

The purpose of this study was to conduct an in-depth investigation into the professional development of beginning cognitive behavioural therapists, as experienced from their own perspective. The results are consistent with other studies that highlight gaining professional confidence as a key task of the beginning phase in therapist development (Bischoff, 1997; Bischoff *et al*., 2002; Hill *et al*., 2007; Skovholt and Rønnestad, 1992). The process was conceptualized into three phases, namely Externally Based Confidence in CBT, Internalized Confidence in CBT, and Therapists' Self-Confidence. In all these phases, an interplay between professional and personal sources seems to be crucial for the development of participants' professional confidence. The importance of this interplay was previously demonstrated by a number of studies in the fields of professional identity formation (e.g. Auxier *et al*., 2003; Howard *et al*., 2006), development of a personal theory of counselling and psychotherapy (e.g. Fitzpatrick *et al*., 2010; Najavits, 1997), and development of personal working style (e.g. Carlsson et al., 2011; Hill *et al*., 1981; Maruniakova *et al*., 2016). For instance, in a study on the professional development of beginning Gestalt counsellors (Maruniakova *et al*., 2016) the authors indicated that personal aspects formed the core of the counsellors' personal working style, which was further developed through a conscious reflection and cultivation of the counsellors' personal qualities (e.g. strengthening their natural skills; utilization of personal experiences) and an adoption of new professional competencies (e.g. adopting general counselling rules and ethics; practising techniques and interventions). This is in accordance with the model presented by Bennett-Levy (2006) who posited that the Personal Self (self-schema or the normal self) and the Professional Self (self-as-therapist schema) cannot be divorced during the therapist competence development. According to this model, some of the elements of the newly established therapist identity are shared in common with the Personal Self (e.g. interpersonal skills), whereas other parts are specific (such as technical knowledge and skills). The key skill, then, is to learn when the personal self facilitates professional development and when not.

The personal self of our participants appeared to be crucial from the initial phase of their choice of the CBT training programme. When deciding for a CBT training, participants either felt that CBT orientation matched their pre-existing beliefs well or they saw it as an opportunity to develop both personally and professionally. These findings on the role of personal domain in the therapist's choice of theoretical orientation resonate with previous research (e.g. Boswell *et al*., 2009; Taubner *et al*., 2010; Wolff and Auckenhalter, 2014). In our study, these attributes of the personal self were essential for the establishment of participants' strong confidence in CBT methodology. This methodology seemed to outline a model of an ideal professional self that participants tended to aim for, especially in the first phase of our model. Their overall perception was that 'this is how I as a CBT therapist should work', which – in combination with their self-doubts and low self-confidence as beginners – supported the participants in their adherence to CBT methods at this stage. However, two participants whose professional self had been established before entering the CBT training evaluated CBT methods more critically from the very beginning. Therefore, it seems that a preformed professional self may fuel a more autonomous development from the beginning of a CBT training (cf. Carlsson *et al*., 2011).

During the second phase, participants' professional self became more grounded as they gained more declarative and procedural knowledge (i.e. better understanding of CBT methodology as well as when–then rules, plans, procedures and skills), corresponding with the first developmental stage of therapist learning in the DPR model (Bennett-Levy, 2006). In our sample, the personal self seemed to play an important role in facilitating the transfer of therapeutic knowledge and skills to the professional self. The participants tended to prefer those techniques they personally liked and found beneficial, which ultimately led to the creation of the repertoire of their favourite CBT methods. In terms of the development of their professional confidence, participants reported an increased sense of competence in those methods which they had a chance to practise several times before using with clients. Yet, their self-confidence at this stage was mainly dependent on clients' outcome in each session, and on external feedback from supervisors and more experienced CBT colleagues. Despite having a different research focus and using different methodological approach, Bennett-Levy and Beedie (2007) similarly identified that these two factors (positive or negative experience with clients and external feedback) had a great emotional impact on how CBT trainees perceived their professional competence. In our study, the personal practice of CBT methods on themselves and their peers seemed to be another factor having emotional impact on both participants' competence and confidence at that stage. Such finding supports the previous research on the benefits of SP/SR used as a training tool for clinical practice (e.g. Bennett-Levy *et al*., 2003; Bennett-Levy and Lee, 2014). The personal practice of CBT methods together with external feedback, appeared to be important for the development of participants' ability to reflect on the therapeutic process and also on the roles of their professional and personal selves in this development. Such a finding is in line with extensive work of Bennett-Levy and his international team (e.g. Bennett-Levy and Beedie, 2007; Bennett-Levy *et al*., 2009b) on the role of reflection in the therapist's professional development.

In the third phase, the personal and professional selves began to blend as the personal self turned out to be a valuable source of additional knowledge and skills in the therapeutic situation. This finding supports Bennett-Levy's model (2006) which suggests that while gaining more professional experience, the self-schema becomes more important again. Facing

real clients created an urge for the participants to refine their professional skills in order to be able to flexibly respond to their clients' needs. A mismatch between clients' needs and participants' professional competence encouraged their reflection on the therapeutic process. This increased participants' seeking supervision and also other sources out of the CBT framework. Here, our findings showed a different developmental path from the model presented by Bennett-Levy and Beedie (2007). In their study, CBT trainees evaluated their competence against the standards required of a CBT therapist, and based on that their perceived competence increased or decreased. Our study revealed that, as their professional experience increased, participants' flexibility and their ability to adjust to clients' needs by using various sources seemed to be another key determinant of how they perceived their competence and confidence (besides following the CBT methodology). The participants' openness to non-CBT resources could be attributed to having positive experiences with other approaches as well as to having trainers or supervisors who demonstrated themselves willing to accept a broad spectrum of methods. Alternatively, we may argue that by the integration of non-CBT elements our participants should no longer be considered CBT therapists. In this line of thought, we may hypothesize that the search for non-CBT resources in our sample might have been a consequence of participants not properly understanding the CBT principles and not having developed skills to apply those sensitively and accordingly to their clients' needs. However, a previous study on CBT trainees (Wolff and Auckenhalter, 2014) described a similar process of 'juggling' with various professional experiences while finding one's own professional identity. Furthermore, an experience of disillusionment with one's home approach and some sort of integration/eclecticism seems to be a natural part of therapists' professional development across orientations (Rønnestad and Skovholt, 2003) and it was shown to take place even within the training period (Hill *et al*., 1981). Overall, the developmental pathway in our participants may be perceived as twofold: finding their professional way within the CBT framework (i.e. adopting some elements and rejecting or modifying others) and utilizing non-CBT professional and personal sources.

Limitations

Our findings are based on data collected within a group of participants who were novices in the field of psychotherapy and, specifically, novices in the CBT approach. This fact may have influenced the collected data in several manners. First, participants' responses were limited by their actual level of knowledge and skills in CBT. Their understanding of CBT may have been simplistic and, possibly, biased or misinterpreted. Second, we relied on the participants' self-reports, which may have not reflected their actual clinical practices. Third, this study is based on retrospective accounts, the quality of which depends on interviewees' ability to recollect how they felt and acted in the past and on their ability to reflect upon their experiences.

Furthermore, the results reflect the Czech psychotherapy context. In comparison with CBT training programmes delivered in Western countries, differences in training approach can be identified (e.g. the length of trainees' personal practice of CBT methods). Such differences might lead to variations in trainees and beginning CBT therapists' developmental patterns. The correspondence of our results with other studies in the field, however, supports their validity beyond the Czech context.

While the use of a non-CBT interviewer and analyst was intended to allow the participants to explore their experience more openly, it can be considered a limitation. A researcher with

CBT expertise might have arrived at alternative interpretations of the data, and might, in particular, have had a different perspective on the integration of other, non-CBT, therapeutic approaches into participants' working styles. Since adherence to the model is perceived as vital in CBT, a CBT-oriented researcher might interpret the development of a personal style as undesirable. Consequently, such a researcher might have concluded that establishing a professional self prior to CBT training is a disadvantage in the development of a CBT therapist's identity.

Main points

In our study, we described an empirically derived three-phase model of the development of CBT therapists' professional confidence within and shortly after their training. Based on the results of our study, we may formulate several implications for CBT trainees and beginning therapists, trainers and supervisors:

(1) Be aware of the role of the personal domain in each stage of CBT trainees' professional development.
(2) Develop a training approach that supports and builds on the interplay between the personal and professional domains within training.
(3) In line with Spruill and Benshoff (2000), we suggest that systematic reflection on the personal aspects and their cultivation for the use in the therapeutic context should be included in CBT training programmes. The SP/SR (Bennett-Levy *et al*., 2001, 2003) concept is very instrumental in this regard.
(4) Openly explore moments in which trainees find CBT methods ineffective or inappropriate and support them in finding a solution that works for them while abiding by the CBT methodology. Trainees' tendency to integrate non-CBT elements into their practice might need to be taken into consideration despite formal requirements for adherence to CBT models.

Ethical statement

Informed consent was obtained before each interview, and the ethical principles of the American Psychological Association were followed throughout the entire study (American Psychological Association, 2010).

Conflicts of interests

Lenka Maruniakova and Tomas Rihacek have no conflicts of interest with respect to this publication.

Financial support

This study was supported by the Specific University Research grant no. MUNI/A/1024/2016 provided by the Czech Ministry of Education, Youth and Sports.

Further reading

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

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: The Guilford Press.

Bischoff RJ (1997). Themes in therapist development during the first three months of clinical experience. *Contemporary Family Therapy* **19**, 563–580. doi: 10.1023/A:1026139206638

Wolff S, Auckenthaler A (2014). Processes of theoretical orientation development in CBT trainees: what internal processes do psychotherapists in training undergo as they 'integrate'? *Journal of Psychotherapy Integration* **24**, 223–237. doi: 10.1037/a0037514

References

Auxier CR, Hughes FR, Kline WB (2003). Identity development in counselors-in-training. *Counselor Education and Supervision* **43**, 25–38. doi: 10.1002/j.1556-6978.2003.tb01827.x

Baldwin SA, Imel ZE (2013). Therapist effects: findings and methods. In MJ Lambert (ed), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (6th edn, pp. 258–297). Hoboken, NJ: John Wiley and Sons.

Barnfield TV, Mathieson FM, Beaumont GR (2007). Assessing the development of competence during postgraduate cognitive-behavioral therapy training. *Journal of Cognitive Psychotherapy: An International Quarterly* **21**, 140–147. doi: 10.1891/088983907780851586.

Beidas RS, Kendall PC (2010). Training therapists in evidence-based practice: a critical review of studies from a systems-contextual perspective. *Clinical Psychology* **17**, 1–30. doi: 10.1111/j.1468-2850.2009.01187.x

Bennett-Levy J (2006). Therapist skills: a cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy* **34**, 57–78. doi: 10.1017/s1352465805002420

Bennett-Levy J, Beedie A (2007). The ups and downs of cognitive therapy training: what happens to trainees perception of their competence during a cognitive therapy training course? *Behavioural and Cognitive Psychotherapy* **35**, 61–75. doi: 10.1017/s1352465806003110

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

Bennett-Levy J, McManus F, Westling BE, Fennell M (2009a). Acquiring and refining CBT skills and competencies: which training methods are perceived to be most effective? *Behavioral and Cognitive Psychotherapy* **37**, 571–583. doi: 10.1017/S1352465809990270

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

Bennett-Levy J, Thwaites R, Chaddock A, Davis M (2009b). Reflective practice in cognitive behavioural therapy: the engine of lifelong learning. In J Stedmon and R Dallos (eds), *Reflective Practice in Psychotherapy and Counselling* (pp. 115–135). Maidenhead: McGraw-Hill/Open University 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.

Bischoff RJ (1997). Themes in therapist development during the first three months of clinical experience. *Contemporary Family Therapy* **19**, 563–580. doi: 10.1023/A:1026139206638

Bischoff RJ, Barton M, Thober J, Hawley R (2002). Events and experiences impacting the development of clinical self-confidence: a study of the first year of client contact. *Journal of Marital and Family Therapy* **28**, 371–382. doi: 10.1111/j.1752-0606.2002.tb01193.x

Boswell JF, Castonguay LG, Pincus AL (2009). Trainee theoretical orientation: profiles and potential predictors. *Journal of Psychotherapy Integration* **19**, 291–312. doi: 10.1037/a0017068

Carlsson J, Norberg J, Sandell R, Schubert J (2011). Searching for recognition: the professional development of psychodynamic psychotherapists during training and the first few years after it. *Psychotherapy Research* **21**, 141–153. doi: 10.1080/10503307.2010.506894

Charmaz K (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage Publications.

Farrand P, Perry J, Linsley S (2010). Enhancing Self-Practice/Self-Reflection (SP/SR) approach to cognitive behaviour training through use of reflective blogs. *Behavioural and Cognitive Psychotherapy* **38**, 473–477. doi: 10.1017/S1352465810000238

Fitzpatrick MR, Kovalak AL, Weaver A (2010). How trainees develop an initial theory of practice: a process model of tentative identifications. *Counselling and Psychotherapy Research* **10**, 93–102. doi: 10.1080/14733141003773790

Freiheit SR, Overholser JC (1997). Training issues in cognitive behavioural psychotherapy. *Journal of Behaviour Therapy and Experimental Psychiatry* **28**, 79–86. doi: 10.1016/S0005-7916(97)00001-3

Glaser BG (1978). *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*. Mill Valley, CA: Sociology Press.

Glaser BG, Strauss AL (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago, IL: Aldine.

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. doi: 10.1017/S1352465810000871

Hatcher RL, Lassiter KD (2007). Initial training in professional psychology: the practicum competencies outline. *Training and Education in Professional Psychology* **1**, 49–63. doi: 10.1037/1931-3918.1.1.49

Hill CE, Charles C, Reed KG (1981). A longitudinal analysis of changes in counseling skills during doctoral training in counseling psychology. *Journal of Counseling Psychology* **28**, 428–436. doi: 10.1037//0022-0167.28.5.428

Hill CE, Sullivan C, Knox S, Schlosser LZ (2007). Becoming psychotherapists experiences of novice trainees in a beginning graduate class. *Psychotherapy Theory, Research, Practice, Training* **44**, 1–27. doi: 10.1037/0033-3204.44.4.434

Howard EE, Inman AG, Altman AN (2006). Critical incidents among novice counselor trainees. *Counselor Education and Supervision* **46**, 88–102. doi: 10.1002/j.1556-6978.2006.tb00015.x

James IA, Blackburn I-M, Milne DL, Reichfelt FK (2001). Moderators of trainee therapists' competence in cognitive therapy. *British Journal of Clinical Psychology* **40**, 131–141. doi: 10.1348/014466501163580

Laireiter A-R, Willutzki U (2003). Self-Reflection and Self-Practice in training of cognitive behaviour therapy: an overview. *Clinical Psychology and Psychotherapy* **10**, 19–30. doi: 10.1002/cpp.348

Leahy RL (2008). The therapeutic relationship in cognitive-behavioral therapy. *Behavioural and Cognitive Psychotherapy* **36**, 769–777. doi: 10.1017/s1352465808004852

Lucock MP, Hall P, Noble R (2006). A survey of influences on the practice of psychotherapists and clinical psychologists in training in the UK. *Clinical Psychology and Psychotherapy* **13**, 123–130. doi: 10.1002/cpp.483.

Maruniakova L, Rihacek T, Roubal J (2016). How beginning counselors learn: the interaction of personal and professional experiences in counselors with an experiential orientation. *Counselling Psychology Quarterly* [online]. doi: 10.1080/09515070.2016.1148013

McManus F, Westbrook D, Vazquez-Montes M, Fennell M, Kennerley H (2010). An evaluation of the effectiveness of Diploma-level training in cognitive behaviour therapy. *Behaviour Research and Therapy* **48**, 1123–1132. doi: 10.1016/j.brat.2010.08.002.

Milne DL, Baker C, Blackburn I-M, James I, Reichelt FK (1999). Effectiveness of cognitive therapy training. *Journal of Behaviour Therapy and Experimental Psychiatry* **30**, 81–92. doi: 10.1016/S0005-7916(99)00011-7

Muse K, McManus F (2013). A systematic review of methods for assessing competence in cognitive behavioural therapy. *Clinical Psychology* **33**, 484–499. doi: https://dx.doi.org/10.1016/j.cpr.2013.01.010

Myles PJ, Milne DL (2004). Outcome evaluation of a brief shared learning programmes in cognitive behavioural therapy. *Behavioural and Cognitive Psychotherapy* **32**, 177–188. doi: https://doi.org/10.1017/S1352465804001183

Najavits LM (1997). Psychotherapists' implicit theories of therapy. *Journal of Psychotherapy Integration* **7**, 1–16. doi: 10.1037/h0101137

Rakovshik S, McManus F (2010). Establishing evidence-based training in cognitive behavioral therapy: a review of current empirical findings and theoretical guidance. *Clinical Psychology Review* **30**, 496–516. doi: 10.1016/j.cpr.2010.03.004

Reiser RP, Milne D (2012). Supervising cognitive-behavioral psychotherapy: pressing needs, impressing possibilities. *Journal of Contemporary Psychotherapy* **42**, 161–171. doi: 10.1007/s10879-011-9200-6

Rihacek T, Roubal J (2017). Personal therapeutic approach: concept and implications. *Journal of Psychotherapy Integration* **27**, 548–560. doi: 10.1037/int0000082

Rønnestad MH, Skovholt TM (2003). The journey of the counselor and therapist: research findings and perspectives on professional development. *Journal of Career and Development* **30**, 5–44. doi: 10.1177/089484530303000102

Schwing AE, LaFollette JR, Steinfeldt JA, Wong YJ (2011). Novice counselors conceptualizations and experiences of therapeutic relationships. *International Journal for the Advancement of Counselling* **33**, 51–63. doi: 10.1007/s10447-010-9112-2

Sharpless BA, Barber JP (2009). A conceptual and empirical review of the meaning, measurement, development, and teaching of intervention competence in clinical psychology. *Clinical Psychology Review* **29**, 47–56. doi: 10.1016/j.cpr.2008.09.008

Skovholt TM, Rønnestad MH (1992). *The Evolving Professional Self: Stages and Themes in Therapist and Counselor Development*. Chichester: John Wiley and Sons.

Spruill DA, Benshoff JM (2000). Helping beginning counselors develop a personal theory of counseling. *Counselor Education and Supervision* **40**, 70–80. doi: 10.1002/j.1556-6978.2000.tb01800.x

Sudak D (2009). Training in cognitive behavioral therapy in psychiatry residency: an overview for educators. *Behavior Modification* **33**, 124–137. doi: 10.1177/1059601108322626

Taubner S, Kächele H, Visbeck A, Rapp A, Sandell R (2010). Therapeutic attitudes and practice patterns among psychotherapy trainees in Germany. *European Journal of Psychotherapy and Counselling* **12**, 361–381. doi: 10.1080/13642537.2010.530085

Wampold BE, Imel ZE (2015). *The Great Psychotherapy Debate: The Evidence for what makes Psychotherapy work* (2nd edn). New York, NY: Routledge.

Wolff S, Auckenthaler A (2014). Processes of theoretical orientation development in CBT trainees: what internal processes do psychotherapists in training undergo as they 'integrate'? *Journal of Psychotherapy Integration* **24**, 223–237. doi: 10.1037/a0037514

Learning objectives

(1) To gain insights into professional development of beginning cognitive behavioural therapy practitioners.
(2) To understand how both professional and personal sources (such as personal life experience, personality traits, personal philosophy and values) contribute to the process of CBT therapists' professional development.
(3) To learn about developmental phases beginning cognitive behavioural therapy practitioners undergo while gaining their professional confidence and what their developmental needs are in each phase.