A Measurable Impact of a Self-Practice/Self-Reflection Programme on the Therapeutic Skills of Experienced Cognitive-Behavioural Therapists

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The need for effective training methods for enhancing cognitive-behavioural therapist competency is not only relevant to new therapists but also to experienced therapists looking to retain and further enhance their skills. Self-practice/self-reflection (SP/SR) is a self-experiential cognitive-behavioural therapy (CBT) training programme, which combines the experience of practicing CBT methods on oneself with structured reflection on the implications of the experience for clinical practice. In order to build on previous qualitative studies of SP/SR, which have mainly focused on trainee CBT therapists, the aim of the current study was to quantify the impact of SP/SR on the therapeutic skills of an experienced cohort of CBT therapists. Fourteen CBT therapists were recruited to participate in an SP/SR programme specifically adapted for experienced therapists. In the context of a quasi-experimental design including multiple baselines within a single-case methodology, therapists provided self-ratings of technical cognitive therapy skill and interpersonal empathic skill at four critical time points: baseline, pre-SP/SR and post-SP/SR and follow-up. Analysis of programme completers ($n = 7$) indicated that SP/SR enhances both technical skill and interpersonal therapeutic skill. Further intention-to-treat group ($n = 14$) analyses including both those who left the programme early ($n = 3$) and those who partially completed the programme ($n = 4$) added to the robustness of findings with respect to technical cognitive therapy skills but not interpersonal empathic skills. It was concluded that SP/SR, as a training and development programme, could offer an avenue to further therapeutic skill enhancement in already experienced CBT therapists. Copyright © 2014 John Wiley & Sons, Ltd.

Key Practitioner Message:
- It was possible to quantify the positive impact of a self-practice/self-reflection (SP/SR) training and development programme within a cohort of experienced cognitive-behavioural (CBT) therapists.
- Through SP/SR, experienced CBT therapists can further enhance their self-perceived therapeutic skills in two key domains; technical cognitive therapy skills and interpersonal empathic skill.
- Further SP/SR studies should aim to incorporate objective measurement of therapeutic skill, ideally from more than one rating source.

Keywords: Cognitive-behavioural Therapy, Self-Practice, Self-Reflection, CBT Training, Therapist Skill Development

MAIN DOCUMENT

Continual professional development is a current requirement of professional psychotherapeutic practice (British Association of Behavioural and Cognitive Psychotherapies (BABCP), 2006; Health and Care Professions Council, 2012). Within the practice of cognitive-behavioural therapy (CBT) in particular, however, there is limited evidence existing at present to suggest which training and development strategies are the most effective at developing which specific CBT competencies (Bennett-Levy, McManus, Westling, & Fennell, 2009a). Furthermore, as therapists progress in their career, it is increasingly likely that they

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will encounter higher degrees of client complexity, either in their own caseload or via the supervision of others. As it is now widely acknowledged that with complex client presentations come a greater requirement to pay attention to the therapeutic alliance and the role of interpersonal processes in therapy (Safran & Segal, 1996; Thwaites & Bennett-Levy, 2007; Waddington, 2002), possession of such interpersonal skills will be crucial for good treatment outcome. Indeed, to ignore such processes is to risk errors that interfere with the therapy such as technical avoidance and an inability to set boundaries (Leahy, 2001), which could, ultimately, amount to therapeutic incompetence (Haarhoff, 2006).

Evidence supports that key interpersonal skills, such as empathy, can be trained (Haarhoff, 2006), particularly if a reflective element is incorporated into the training. The importance of continuous reflection in helping professionals develop from novice to expert is not a new concept (Schön, 1987; Rønnestad & Skovholt, 2003) but has been more recently operationalised within CBT practice, where therapists have been particularly encouraged to attend to the personal aspects of themselves (Bennett-Levy & Thwaites, 2007; Haarhoff & Farrand, 2012). As CBT therapists' beliefs may unknowingly influence their therapeutic approach and decision-making (Haarhoff & Kazantzis, 2007), Sanders and Wills (2005) stress the importance of therapists being able to tune into their own thoughts, feelings and behaviours to address any unhelpful aspects and reduce the possibility of 'therapy interfering effects' (Haarhoff, 2006, p. 126).

In order to understand how such therapist skills can be acquired, Bennett-Levy (2006) has offered his three-system declarative, procedural and reflective (DPR) model. The model predicts that as a therapist becomes more advanced, the reflective system will be utilised to progressively refine the therapist's declarative knowledge and procedural skills (Bennett-Levy et al., 2009a). Reflection becomes increasingly necessary during complex cases, where application of treatment protocols will require therapist flexibility and more unique problem-solving techniques in order to deal with unforeseen circumstances and subtle differences in client presentation (Milne, Claydon, Blackburn, James, & Sheikh, 2001).

In their review of CBT training approaches, Bennett-Levy et al. (2009a) concluded that reflective methods were deemed useful for enhancing procedural skills, with self-experiential work being particularly good for interpersonal skill development. A more recent study also found evidence of pre-post change in self-rated competence in trainee clinical psychologists following training that included a focus on interpersonal process issues as well as technical content (Schneider & Rees, 2012). Other authors have reached similar conclusions about the benefits of including self-reflection alongside the self-practice of CBT techniques to enhance interpersonal awareness in therapists (Bennett-Levy, Thwaites, Chaddock, & Davis, 2009b; Laireiter & Willutzki, 2003). The self-practice/self-reflection (SP/SR) training paradigm combines these essential elements.

SP/SR is a structured programme developed by Bennett-Levy and colleagues (2001, 2003), which involves practising a series of CBT techniques on the self followed by formal reflection and evaluation of the experience. As SP/SR offers a personal experiential approach to training, it has the potential to offer avenues to skill enhancement that may not be possible via traditional means. For example, as SP/SR focuses directly on the *self-schema (the person of the therapist)* as well as the *self-as-therapist schema* (Bennett-Levy, 2006), it offers a training strategy that engages the reflective system to reflect upon learning experiences that impact on the beliefs of a therapist at a personal as well as a professional level and so is most likely to aid in the development of interpersonal skills (Thwaites & Bennett-Levy, 2007). Since its conception in early 2000s, SP/SR has seen its evidence-base grow in empirical support across a range of different delivery models, including co-therapy pairs (Bennett-Levy, Lee, Travers, Pohlman, & Hamernik, 2003), manualised workbooks (Bennett-Levy et al., 2001; Chaddock, 2007b; Haarhoff, Gibson, & Flett, 2011), self-case studies (Haarhoff & Stenhouse, 2004; Fraser & Wilson, 2010) and reflective blogs (Farrand, Perry, & Linsley, 2010). Although these studies show impact on conceptual, technical and interpersonal skill domains, to date, there has been a heavy reliance on qualitative data, and so it has been suggested that quantitative measurement needs to be incorporated (Haarhoff & Farrand, 2012).

Initial evidence from unpublished doctoral theses suggests that previous qualitative results do translate into quantitatively measurable differences in skill as assessed by trainee therapist's self-ratings of empathy and competence in CBT (Chaddock, 2007b) and in improved quality in CBT written case conceptualisations (Haarhoff, 2008). However, as participants were trainee therapists, it has been difficult to discern what proportion of skill development was due to SP/SR and which to other training methods given that trainees are likely to be on a general learning curve throughout their training (Schneider & Rees, 2012). There are therefore two important reasons for evaluating SP/SR with experienced therapists. First, in contrast to typical trainee SP/SR studies, the experienced therapists in the present study were not concurrently engaged in a general CBT training programme. Therefore, the study design allows for a clearer discrimination of the specific impact of SP/SR (Bennett-Levy et al., 2003). Second, despite the wealth of literature describing the differences between the learning needs of trainees and more advanced therapists, little is known about how experienced therapists may respond to such self-experiential development work and what its impact might be (Haarhoff, 2006).

Study Aims

This study aimed to contribute to the quantitative evidence-base, making use of a strengthened design, to explore whether completing a 10-week workbook-based SP/SR programme results in a measurable change in self-perceived therapeutic skill of experienced CBT therapists.

Hypotheses

On the basis of the DPR model (Bennett-Levy, 2006) and previous SP/SR study findings, it was hypothesised that completing SP/SR would result in measurable enhancement of self-perceived therapeutic skill in participants compared with baseline in terms of (i) cognitive therapy (CT) skills and (ii) empathy skills.

METHOD

Fourteen clinicians from the north of England employed by five different NHS Trusts, who had been formally trained in CBT with a minimum of 3 years experience post-CBT training, were recruited to the study. From the initial 14 recruited (the *intention-to-treat (ITT)* group), three left due to reported work and time pressures (the *drop-outs*), four started SP/SR but did not complete it within the study's timescale (finishing at Weeks 4, 7, 8 and 8, respectively) (the *partial completers*), leaving seven participants who completed SP/SR through to follow-up (the *completers)*. Table 1 displays participant demographics for the *ITT* group and *completers* subgroup.

Design

Due to anticipated low recruitment, the study was initially designed as a multiple-baseline single case experiment.

However, with above expected recruitment and collection of data at four critical time points, this allowed analysis as a case series or uncontrolled trial with a pre-post design including baseline (double baseline measurement), intervention (SP/SR) and follow-up phases. Participants were allocated randomly to baseline start dates to achieve replication both across and within each baseline to enable a more controlled design (Schneider & Rees, 2012).

Self-practice/Self-reflection Workbook

Self-practice/self-reflection was delivered in a manualised workbook format, which offered a 10-week programme for participants to work their way through individually. This required participants to engage in a series of structured exercises and activities that could form part of a typical course of CBT. For example, participants were asked to identify beliefs that caused them difficulty at both a personal and a professional level at the start of the programme. They were then asked to rate their strength of conviction in these beliefs on a weekly basis and to complete various activities including self-formulations, thought records and behavioural experiments, using the identified beliefs when relevant, over the course of the programme. At the end of each week, participants were required to provide a formal written reflection on each activity, evaluating their experience and considering any implications for future clinical practice. These reflections were then collated and emailed to all participants anonymously via the first author. Adaptations were made to the original workbook (Bennett-Levy et. al., 2001) to make it more appropriate for experienced CBT therapists. For example, reflective questions were rewritten and extended to include training and supervision implications, thus building on the clinical practice implications of the original programme.

Table 1. Participant demographics

	Intention to treat ($n = 14$)	Completers ($n = 7$)
Gender	8M, 6F	3M, 4F
Mean age (SD, range)	45 yrs (5, 35–54)	41 yrs (12, 35–54)
Mean yrs of post-professional qualification experience	18 yrs (6, 6–25)	17 yrs (7, 6–25)
Mean yrs of post-CBT training experience	9 yrs (6, 3–23)	8 yrs (4, 4–16)
Mean number of clients seen each week	10 clients (7, 3–25)	10 clients (7, 3–25)
Professional discipline	Clinical psychology ($n = 7$) Nursing ($n = 5$) Psychiatry ($n = 2$)	Clinical psychology ($n = 3$) Nursing ($n = 3$) Psychiatry ($n = 1$)
Client group	Working age adults ($n = 12$) Adolescents ($n = 1$) Older adults ($n = 1$)	Working age adults ($n = 7$)

Measures

Participants provided self-ratings of their CT technical skill and empathic skill in their concurrent clinical practice via two novel scales, which had been previously piloted by Chaddock (2007b): the Cognitive Therapist Self-Monitoring Scale (CTSMS; Thwaites, Freeston, Bennett-Levy, Cromarty & Armstrong, 2003) and the Cognitive Therapist Empathy Scale (CTES; Thwaites, Bennett-Levy, Freeston, Armstrong & Cromarty, 2003). The CTSMS is a 12-item scale devised from the Revised CT Scale (Blackburn et al., 2001) but adapted for self-administration assessing self-perceived technical competence across a range of CBT skills. Items are rated from 0 ('novice') through 50 ('competent') to 100 ('expert'). The CTSMS is made up of two subscales: general therapeutic skills still relevant to CT (e.g., efficient use of time) and CT-specific skills (e.g., eliciting key cognitions). The CTES contains 21 statements on self-perceived therapist empathy towards a client with items rated from 0 ('completely disagree') to 100 ('completely agree'). The CTES is made up of four subscales: empathic attunement, communication, stance and knowledge, which are theoretically derived from Thwaites and Bennett-Levy's (2007) model of therapist empathy in CBT.

These scales were originally developed in 2003 by tutors on two northern CBT training courses who were piloting SP/SR with their trainees and were in need of a sensitive measure. Reliability estimates are reported in Table 2. In line with the study aims, efforts were made to increase the sensitivity of measurement on both scales. We reasoned that for experienced therapists, the impact of SP/SR training might only show itself with the clients who provided the greatest therapeutic challenge. So, the CTSMS and CTES measures both required two ratings:

1. A general rating in relation to all clients seen over the *last 7 days*.

2. A specific rating in relation to the *most difficult client*, i.e., the client whom the therapist found most difficult to relate to interpersonally that week.

Procedure

Baseline phase: once participants signed up to the study, they were randomised to one of four baselines, the longest being 7 weeks and the shortest being 4 weeks. This meant that participants began their self-monitoring at different points in time depending on which baseline condition they were allocated. Participants completed the CTSMS and CTES in their entirety when they started their baseline (time point: T1, pre-baseline). They were also required to complete weekly self-monitoring of selected items from both scales as part of the single case-series design, but only data from the four critical time points were used for the current analysis. Participants were only required to self-monitor at this stage.

SP/SR phase: participants all began the SP/SR workbook at the same time. They completed the CTSMS and CTES for a second and third time: at the start of SP/SR (T2, pre-SP/SR) and at the end of the programme (T3, post-SP/SR).

Follow-up phase: following the SP/SR programme, participants continued with their self-monitoring measure for an additional 4 weeks. At the end of the follow-up period, participants completed the CTSMS and CTES for the final time (T4, follow-up).

Data Analysis

In order to identify any quantitative change in self-perceived therapeutic skill, a series of repeated measures analysis of variance (ANOVAs) were conducted to identify any

Table 2. Descriptive statistics and internal consistency reliability estimates for the Cognitive Therapist Self-Monitoring Scale and Cognitive Therapist Empathy Scale in a pilot sample

Scale items	Mean	SD	Score range	Alpha	
				Last 7 days rating	MDC rating
Cognitive Therapist Self-Monitoring Scale					
Total scale	58.29	11.81	5–95	0.96	0.96
Subscale 1: general items	59.38	11.37	20–95	0.91	0.87
Subscale 2: cognitive therapy-specific items	57.50	12.90	5–95	0.95	0.95
Cognitive Therapist Empathy Scale					
Total scale	68.48	9.29	10–100	0.92	0.91
Subscale 1: empathic attunement	66.85	10.19	10–100	0.86	0.84
Subscale 2: empathic communication	66.50	10.68	10–100	0.89	0.86
Subscale 3: empathic stance	66.52	15.14	10–100	0.74	0.71
Subscale 4: empathic knowledge	73.06	11.62	10–100	0.87	0.81

SD = standard deviation. MDC = most difficult client.
NB: means, SD and score ranges are given as an average across both rating reference points.

differences on the mean subscale scores of the CTSMS and CTES across the four critical time points.

RESULTS

Measure Reliability

As amendments had been made to both the CTSMS and CTES, a Cronbach's alpha was calculated for both measures. A combined sample comprised data collected at baseline for the study participants ($n = 14$) and also data collected from a further 21 people (all trainees on two northern CBT training courses at the time of the study), given a total sample of $n = 35$. Internal consistency values, as estimated by Cronbach's alpha, are provided in Table 2 for both measures, separated by subscale.

Plan of Analyses

Participants were split into three groups as described in the *Participants* section. To test the main hypotheses, a *completer* analysis ($n = 7$) was conducted. In addition, an *ITT analysis* ($n = 14$) was also performed and included all *completers*, *partial completers* ($n = 4$) and *drop-outs* ($n = 3$). For the *ITT* analysis, all missing observations were carried forward from the last recorded observation in a more conservative analysis.

A series of repeated measures ANOVAs were used to examine any changes in the dependent variables (CTES and CTSMS self-ratings) according to the independent variables of time (pre-baseline, pre-SP/SR, post-SP/SR and follow-up) × rating reference (last 7 days and most difficult client) × subscale (CTSMS: general and CT-specific; CTES: empathic attunement, communication, stance and knowledge). All interactions between these main effects were also examined and reported when significant. Three specific contrasts tested the effects of SP/SR (T1 and T2 versus T3 and T4), change within baseline (T1 versus T2) and change within follow-up (T3 versus T4).

Cognitive Therapy Skills

The descriptive statistics for the CTSMS scores across the four time points for both groups (*completer* and *ITT*) are given in Table 3. A priori (special) contrasts were conducted within the repeated measure $4 \times 2 \times 2$ (time × reference × subscale) ANOVA in order to make specific predictions about the direction of any expected difference. Contrasts were examined at three levels relating to the time factor. To test the hypothesis that SP/SR would increase skills, the first contrast compared T1 and T2 (pre-baseline and pre-SP/SR combined) against T2 and T3 (post-SP/SR and follow-up combined) in the *completer* group, and was statistically significant $F(1,6) = 48.85$, $p < 0.001$, $\eta^2 = 0.89$, power = 1.00.

No significant differences were found for either contrast within baseline, $F(1,6) = 0.082$, $p = 0.785$, $\eta^2 = 0.013$, power = 0.057 or within follow-up $F(1,6) = 0.033$, $p = 0.862$, $\eta^2 = 0.005$, power = 0.053; effect sizes for these comparisons were trivial. Thus, change occurred during the SP/SR phase.

There were no other significant main effects of reference $F(1,6) = 4.361$, $p = 0.082$, $\eta^2 = 0.421$, power = 0.419, or subscale $F(1,6) = 1.979$, $p = 0.209$, $\eta^2 = 0.248$, power = 0.221. However, importantly, there was a significant time × reference interaction $F(1,6) = 6.178$, $p = 0.047$, $\eta^2 = 0.507$, power = 0.549 at time contrast 1. Inspection of Figure 1 suggested that the *most*

Table 3. Means (M), standard errors (SE) and 95% confidence intervals (CI) for the Cognitive Therapist Self-Monitoring Scale (CTSMS) scores per rating reference and subscale for both the completer and ITT groups at the four critical time points

	Time 1 (pre-baseline)			Time 2 (pre-SP/SR)			Time 3 (post-SP/SR)			Time 4 (follow up)		
	M	SE	95% CI	M	SE	95% CI	M	SE	95% CI	M	SE	95% CI
Completers (n = 7)												
Rating Reference												
Last 7 Days	68.29	4.26	57.85–78.72	68.57	3.35	60.38–76.77	70.57	3.05	63.10–78.04	71.79	3.72	62.68–80.89
MD Client	50.07	6.22	34.86–65.29	46.93	7.57	28.41–65.45	60.14	7.86	40.92–79.37	60.14	7.75	41.12–79.10
Subscale												
General	60.36	3.66	51.41–69.31	59.86	5.70	45.92–73.80	65.07	4.09	55.06–75.08	68.00	4.49	57.02–78.98
CT-Specific	58.00	4.32	47.43–68.57	55.61	3.97	45.93–65.35	65.64	4.42	54.83–76.45	63.93	4.83	52.12–75.74
ITT (n = 14)												
Rating reference												
Last 7 days	66.14	4.27	56.93–75.36	68.75	2.75	62.81–74.69	69.75	2.68	63.97–75.53	70.00	3.00	63.52–76.49
MD client	51.57	4.56	41.72–61.42	52.46	5.01	41.65–63.28	59.07	4.88	48.53–69.61	58.11	4.94	47.43–68.79
Subscale												
General	59.61	3.92	51.13–68.09	62.11	3.90	53.67–70.54	64.71	3.35	57.48–71.95	65.18	3.72	57.15–73.21
CT-specific	58.11	4.08	49.30–66.91	59.11	3.13	52.34–65.88	64.11	3.16	57.29–70.92	62.93	3.34	55.72–70.14

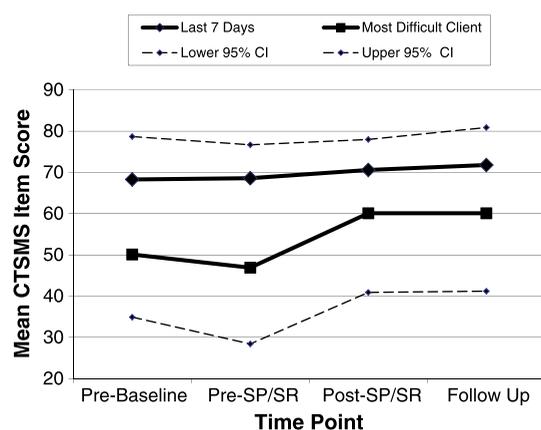CT = cognitive therapy. MD = most difficult. ITT = intention-to-treat group.

Figure 1. Change in self-rated cognitive therapy skills over time by rating reference for the completer group

difficult client rating was carrying this difference across time, or, taken together, these results indicated that for *completers*, self-perceived CT skills increased during SP/SR with the difference being mostly due to ratings for the most difficult client of the week. Furthermore, this difference was specific to the SP/SR phase as there was no significant change in skill in either the baseline or follow-up phases. Figure 1 displays the CTSMS ratings for each of the four time points by rating reference. The 'lower/upper 95% confidence intervals' series represent the average of all the lower/upper 95% confidence intervals for the means of the ratings shown, as per the study time points, collapsed

across the two rating reference points or the CTSMS and CTES subscales.

When the above analysis was performed again with the *ITT* group, the significant contrast (combined pre versus combined post) remained: $F(1,13) = 9.415$, $p = 0.009$, $\eta^2 = 0.420$, power $= 0.809$. As with the *completers*, the second, $F(1,13) = 0.277$, $p = 0.608$, $\eta^2 = 0.021$, power $= 0.078$ and third, $F(1,13) = 0.042$, $p = 0.841$, $\eta^2 = 0.003$, power $= 0.054$ contrasts were not significant, indicating no change in either the baseline or follow-up phases for the *ITT* group. These results suggest that participants' self-ratings on the CTSMS were significantly higher post-SP/SR than pre-SP/SR based on the conservative assumption, which assumed that *partial completers* and *drop-outs* would have continued to rate their skills at the same level as their last recorded observation had they completed SP/SR.

Empathy Skills

The descriptive statistics for the CTES scores across the four time points for both groups (*completer* and *ITT*) are given in Table 4. As the *empathic stance* subscale contained some items where higher ratings indicated lower stance, these items were reverse scored for the purpose of analysis.

For the repeated measures $4 \times 2 \times 4$ (time × reference × subscale) ANOVAs on the CTES ratings, special contrasts were again performed. For the time factor, these contrasts were the same as before. For the *completer* group, the first contrast was significant, $F(1,6) = 6.033$, $p = 0.049$, $\eta^2 = 0.501$,

Table 4. Means (M), standard errors (SE) and 95% confidence intervals (CI) for the Cognitive Therapist Empathy Scale (CTES) scores per rating reference and subscale for both the completer and ITT groups at the four critical time points

	Time 1 (pre-baseline)			Time 2 (pre-SP/SR)			Time 3 (post-SP/SR)			Time 4 (follow up)		
	M	SE	95% CI	M	SE	95% CI	M	SE	95% CI	M	SE	95% CI
Completers (n = 7)												
Rating reference												
Last 7 days	72.96	3.80	63.66–82.27	74.29	3.73	65.16–83.41	77.00	4.17	66.80–87.21	76.36	4.49	65.37–87.35
MD client	59.11	5.86	44.77–73.45	57.93	7.53	39.51–76.35	67.39	9.38	44.44–90.35	66.64	8.47	45.92–87.37
Subscale												
Attunement	67.36	4.79	55.64–79.07	64.79	5.60	51.08–78.49	69.21	6.59	53.08–85.35	69.29	6.31	53.84–84.73
Communication	63.07	3.74	53.91–72.23	62.79	6.11	47.83–77.75	69.36	6.22	54.13–84.58	66.86	6.92	49.92–83.80
Stance	60.71	6.75	44.21–77.22	66.71	5.57	53.08–80.35	76.21	6.04	61.44–90.99	77.64	6.02	62.93–92.36
Knowledge	73.00	5.71	59.03–86.97	70.14	5.26	57.28–83.01	74.00	6.36	58.44–89.57	72.21	6.08	57.33–87.10
ITT (n = 14)												
Rating reference												
Last 7 days	71.54	2.97	65.14–77.93	72.36	3.40	65.01–79.70	73.71	3.59	65.95–81.47	72.41	3.90	64.00–80.83
MD client	61.25	3.64	53.38–69.12	60.55	4.61	50.59–70.52	65.29	5.32	53.79–76.78	63.59	5.12	52.53–74.65
Subscale												
Attunement	67.00	2.90	60.73–73.27	66.25	4.01	57.58–74.92	68.46	4.33	59.11–77.82	67.29	4.54	57.48–77.10
Communication	64.25	3.07	57.62–70.88	63.82	4.16	54.83–72.81	67.11	4.23	57.96–76.25	64.64	4.68	54.53–74.76
Stance	61.04	4.61	51.01–71.00	66.25	4.05	57.50–75.00	71.00	4.44	61.41–80.59	70.07	4.76	59.73–80.35
Knowledge	73.29	3.69	65.32–81.26	69.50	3.64	61.64–77.36	71.43	4.08	62.61–80.25	70.00	4.00	61.35–78.69

MD = most difficult. ITT = intention-to-treat group.

power = 0.540, but neither the second, $F(1,6) = 0.001$, $p = 0.980$, $\eta^2 < 0.001$, power = 0.050, nor the third were significant, $F(1,6) = 0.150$, $p = 0.712$, $\eta^2 = 0.024$, power = 0.063. The latter two contrasts accounted for either trivial or no variance. As there were no other significant time interactions, this suggests that self-perceived empathy skills were significantly higher post-SP/SR than pre-SP/SR for those participants who completed the programme.

When the above analysis was performed again with the *ITT* group, none of the contrasts were significant, $F(1,13) = 2.017$, $p = 0.179$, $\eta^2 = 0.134$, power = 0.260; $F(1,13) = 0.001$, $p = 0.971$, $\eta^2 < 0.001$, power = 0.050; and $F(1,13) = 1.113$, $p = 0.311$, $\eta^2 = 0.079$, power = 0.165, respectively. This suggests that the self-ratings of empathy for the *ITT* group were no different after SP/SR than before, although, as noted, this was a conservative last observation carried forward analysis.

DISCUSSION

As hypothesised, the results indicated that a measurable enhancement of self-perceived therapeutic skill was detected following the completion of SP/SR for a group of experienced CBT therapists. Self-perceived skills in two different domains, technical CT skill and interpersonal empathic skill, were rated significantly higher after SP/SR than before, suggesting that therapeutic skill was enhanced for the seven programme completers.

Given that the self-reported differences occurred within the active SP/SR phase and were not evident during either baseline or follow-up, we can be confident that this perceived skill enhancement was due to the specific impact of SP/SR. Moreover, owing to the strength of the design with a double-baseline, follow-up phase and the ITT analysis, and the fact that the participants were not engaged in concurrent CBT training, it is highly likely that the therapists in the study considered themselves as significantly more competent in their therapeutic skills directly as a result the SP/SR programme.

The current study has offered quantitative data to support previous qualitative findings regarding the benefits of SP/SR (Bennett-Levy et al., 2001; Bennett-Levy et al., 2003) and has contributed to the literature in offering empirical evidence to support both personal experiential work and the role of reflection in practitioner development in enhancing CBT skill and competencies. The findings were also consistent with the predictions of Bennett-Levy's (2006) DPR model and the suggestion that SP/SR can offer a specific contribution to interpersonal skill development (Thwaites & Bennett-Levy, 2007) with attention to the personal self, accompanied by self-reflection (Laireiter & Willutzki, 2003), being a necessary part of this development.

Although only half of the participants completed the SP/SR programme through to the follow-up stage, the results of the more conservative ITT analysis demonstrated that self-perceived change in technical CT skill was a robust finding. However, this result did not hold for the self-rated empathy skills. For the purpose of measurement, the current study made use of Thwaites and Bennett-Levy's (2007) four components of empathy to operationalise a rating of therapist empathic skill. However, Chaddock (2007a, p.2) has suggested that CBT-specific definitions should consider empathy to be 'the property of the dyadic relationship between therapist and client, and not merely in terms of what the therapist and client may independently experience'. If empathy can be conceived as a co-constructed property of the therapist–client dyad, then this has implications for how empathy is defined, measured and modelled. For example, it may be that the measurement strategy in the current study was limited in capturing only therapist ratings.

It is also recognised that the study participants comprised a self-selecting sample. This may have meant that those who volunteered for the study represented a particular group, i.e., those who were already reflective practitioners. In addition, certain demand characteristics may also have been in operation with participants being influenced by the suggestion of the potential benefit of SP/SR, making self-serving biases possible. As previous research has demonstrated, however, level of engagement is a key issue in terms of what benefit can be gained from the programme (Chaddock, 2007b). Therefore, as Bennett-Levy and Lee (2014) have discussed, to participate in such SP/SR programmes requires participants to be motivated as confidence in one's own skills and competence level can be challenged during the process (Bennett-Levy & Beedie, 2007). The possibility that SP/SR may not be universally beneficial to all groups of participants, however, is an important consideration for the programme's future development.

A further limitation is the lack of objective measurement in this study. As noted by Haarhoff and Farrand (2012) and others (Thwaites, Bennett-Levy, Davis, & Chaddock, 2014), there has been an over-reliance on self-report measures in this area. Niemi and Tiuraniemi (2010) note that there is a need for future studies to make use of objective skill ratings, starting with pre-training measures of competence, followed by more frequent follow-up measures. However, in terms of the history of SP/SR, the programme has followed a natural process of development from original concept, through initial qualitative investigation to quantitative evidence, first with trainee therapists and now extending to experienced therapists. Furthermore, although self-assessment can be an unreliable measure, as Mathieson, Barnfield, and Beaumont (2009) discuss, it may still be important to attend to as, although it may not be objective measurement, it is likely to reflect the rater's confidence in their own competence as a CBT therapist.

It is also acknowledged that the content of the SP/SR workbook in this study largely followed a traditional Beckian approach with a strong emphasis on changing

behaviour and the content of cognitions (Beck, 2011). On this occasion, the programme focused on a skill set commensurate with this approach. As CBT practice continues to evolve with different schools of thought emphasising particular therapist skill sets, it will be important for SP/SR to continue to develop alongside these approaches. Indeed, an SP/SR manual currently in preparation includes an increased focus upon behavioural activation, transdiagnostic approaches and strengths-based work (Bennett-Levy, Thwaites, Haarhoff, & Perry, 2014).

Future research should aim to reconsider how empathy in CBT is defined, measured and modelled, and increase measurement sensitivity further by continuing to use specific, rather than general rating reference points. Future work also needs to consider how best to incorporate more objective measurement of therapist competence, perhaps from the supervisor's or client's perspective and will also need to take into account which particular CBT approach, and therefore set of skills, are the focus of attention. A longer follow-up period would also be preferable. The ultimate goal, as suggested by Haarhoff and Farrand (2012) would be to achieve a measurable impact on therapeutic outcome. However, as demonstrating a measurable impact on therapist skills is an initial step, these findings, especially those that were less robust, should first be replicated to further strengthen the SP/SR evidence base.

If SP/SR does lead to enhanced therapeutic skill, which previous and current research findings indicate, then there would be a clear rationale for promoting the programme, not only during training but also as a form of personal and professional development for more experienced therapists or perhaps as a way of renewing CBT accreditation (British Association of Behavioural and Cognitive Psychotherapies (BABCP), 2006). For example, the above findings suggest that when working with their 'most difficult' clients, even very experienced therapists can find that their ability to be empathic and competently deliver CT is lower and more variable, by their own ratings. Also, it appears that experienced therapists' empathic stance can vary and this seems to be related to the therapist's emotional reaction to a given client on a given day. As previously suggested (Haarhoff, 2006; Sanders & Wills, 2005), this makes a strong case for the need for therapists to attend to and manage the emotions that they experience during sessions. In addition, there is increasing suggestion that SP/SR can be extended beyond the individual practitioner on a one-off occasion and may be successfully utilised in supervision as well as for continued professional development throughout one's career (Bennett-Levy & Thwaites, 2007; Thwaites et al., 2014). Given also that it will be the more experienced CBT therapists that are likely to be responsible for managing complex cases, it is argued that SP/SR impacts on self-reported skills of crucial importance to this group, such as those in the interpersonal domain.

Conclusions

Historically, practitioners of CBT have emphasised the importance of evidence-based practice and have sought to promote a philosophy of ongoing evaluation of its models and methods (Department of Health, 2008). The same standards need to be applied to the training of CBT. This study has offered evidence to suggest that further skill development in experienced therapists was both possible and measurable. Although little can be said about the actual level of competence demonstrated, as no objective measurement of skill was made, if self-perceived skill enhancement was reported, across two different skill domains, then this can be seen to be the first step in that process. Therefore, aside from the limits of drawing conclusions from a quasi-experimental design, it is proposed that SP/SR be put forward as a training and development programme capable of providing skill enhancement in already experienced CBT therapists.

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