INVITED CONTRIBUTION

Developing Metacompetence in Low Intensity Cognitive-Behavioural Therapy (CBT) Interventions: Evaluating a Self-Practice/Self-Reflection Programme for Experienced Low Intensity CBT Practitioners

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Self-practice/self-reflection (SP/SR) is a targeted training and professional development strategy in which clinicians practice cognitive-behavioural therapy (CBT) techniques and processes on themselves and then working through a structured process of self-reflection. Previous studies with CBT trainees and experienced mental health practitioners have found that SP/SR or experiencing CBT “from the inside out” has been perceived by participants as increasing competency in a number of important areas and increasing therapist flexibility and artistry. Low intensity (LI) practitioners are identified as a relatively new addition to mental health service delivery in the UK. These workers are differentiated from traditional mental health practitioners by a shorter training period, the delivery of a circumscribed number of CBT interventions, and a very high weekly patient load. This study, the first of its kind, reports outcomes from an SP/SR programme undertaken by seven experienced LI CBT practitioners. Participants used the following measures to track their experience of the programme: time spent on programme, personal- and therapy-related belief rating, goals attained, and perceived skill rated for average and most difficult patients. Results showed a positive change in work-related skill and behaviour change, particularly when working with the more difficult patients. The findings are consistent with those found in other groups of therapists (e.g., trainee CBT therapists and highly experienced CBT therapists), suggesting that SP/SR may be a valuable addition to LI intensity training and professional development. These findings are discussed in the context of the particular needs of LI practitioners.

Key words: CBT training; low intensity; metacompetence; reflection; self-practice/self-reflection; SP/SR.

Introduction

The unique role of the low intensity (LI) practitioner was developed in the English National Health Service (NHS) as part of the Improving Access to Psychological Therapies (IAPT) programme (Department of Health, 2008). LI practitioners are called psychological well-being practitioners (PWPs) in the NHS. They provide LI interventions (largely cognitive-behavioural therapy [CBT]-based guided self-help) for depression and a selection of anxiety disorders in line with National Institute for Health and Care Excellence (NICE) guidance (NICE, 2011). They undertake a 45-day training programme and intensive supervision over the course of a year. This role is crucial within stepped care treatment programmes in ensuring that large numbers of patients can access evidence-based interventions.

LI interventions involve a high number of shorter (than traditional CBT) appointments (often 30 min) each day. Therefore, each practitioner sees significantly more patients each week than traditional therapists. This translates into treatment for 175–250 patients per year. Consequently, PWPs have the potential to become highly skilled in the prescribed number of interventions in which they are trained (e.g., assessment, formulation, behavioural activation, cognitive restructuring, exposure and problem solving).

Significant clinical experience is one of the ingredients for moving from competence to a high level of skill (Newman, 2013) and this is plentiful for PWPs. However, clinical experience on its own is not enough (Skovholt, Ronnestad, & Jennings, 1997). Authors such as Bennett-Levy (2006) and Thwaites, Bennett-Levy, Davis, and Chaddock (2014) have suggested that reflective capacity is central in enabling therapists to learn from clinical experience and to refine their skills.

The experience of some of the authors of this article1 suggests that there are two main challenges to the role of the PWP, both of which are related to the high caseloads and throughput of patients: first is finding time to reflect and learn from the wealth of clinical experience in order to fine-tune the delivery of interventions; and second is the prevention of practitioner burnout. Although both these potential challenges are addressed to some extent by the significant supervision component usually delivered to support the role (i.e., weekly case management and regular group clinical supervision), neither of these approaches aims to directly build reflective skills or provides a structure to

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facilitate reflection on practice and turn this into new procedural learning. In addition, PWPs have not traditionally had the chance to experience LI interventions for themselves, which could be a valuable source of learning, e.g., experience the intervention and reflect (with guidance) on the way that they could adapt and deliver their interventions.

Within the field of CBT, a focused training strategy has been developed that gives practitioners a structured experience of using CBT techniques and processes on themselves (self-practice [SP]) and reflecting on that experience (self-reflection [SR]). SP/SR can be utilised at a basic level during training or later in the practitioner’s career to help the individual move from competence to metacompetence (Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015; Thwaites et al., 2014). Given the growing evidence base around SP/SR programmes in the development of both novice and highly experienced CBT therapists, it appeared valid and appropriate to adapt this intervention for PWPs to meet the identified needs described above.

To date, SP/SR programmes have most often been delivered within a group format using a manualised workbook (e.g., Bennett-Levy et al., 2001; Davis, Thwaites, Freeston & Bennett-Levy, 2014). Detailed descriptions of SP/SR can be found elsewhere (e.g., Thwaites et al., 2014; Bennett-Levy et al., 2015). In brief, participants complete a relevant CBT SP exercise (e.g., self-formulation, behavioural experiment) and then work through a range of reflective questions around their SP experience (e.g., clarification of the experience, learning about themselves as clinicians or in their wider lives, implications for their practice, and understanding of CBT theory). The participants then share their reflections on the process (rather than the content) with their fellow group members, which may then lead to further reflections and discussion around new shared learning.

There is a growing evidence base around the effect of SP/SR on CBT therapists and clinical psychologists at varying stages in their careers (Gale & Schröder, 2014). Thwaites et al. (2014) summarised the main SP/SR research findings to date and suggested that it can lead to change in:

- CBT knowledge;
- Procedural skills (i.e., when and how we implement knowledge in practice) especially relating to the process of change and interpersonal factors;
- Therapeutic flexibility and creativity;
- Reflective skills; and
- Beliefs relating to both the therapist self and personal self (Davis et al., 2014).

Although there are some promising initial findings around the usage of SP/SR during LI training and its role in helping PWPs to establish basic competency (Chellingsworth & Farrand, 2013), there is currently no evidence base around the use of SP/SR as an intervention with experienced or qualified PWPs. This study therefore aimed to evaluate the self-perceived impact of a 12-module SP/SR programme on personal and therapist beliefs, and levels of skill in a group of PWPs.

In line with previous SP/SR research findings (summarised in Bennett-Levy et al., 2015; Gale & Schröder, 2014, Thwaites et al., 2014), the aim was to explore four main hypotheses:

1. Participants will report a greater understanding of the LI interventions that they utilise and will be able to describe changes in the way they implement these, i.e., improved explanation, increased flexibility, greater ability to identify potential stuck points, and troubleshoot.
2. SP/SR will lead to changes in target beliefs and behaviours (both personal and work related).
3. There will be differential engagement patterns and differential responses to SP/SR—both between participants and also between individual modules. (Bennett-Levy & Lee, 2014; Chaddock, Thwaites, Bennett-Levy, & Freeston, 2014)
4. There will be an initial de-skilling for some participants as they start to experience CBT interventions “from the inside out” (Chaddock et al., 2014; Davis et al., 2015).

**Method**

**Participants**

A total of 39 (36 female, 3 male) qualified PWPs within a large psychological therapy service received 1-day training on reflection in an LI work context (including the role of reflection in skill development). Following this, they were provided with information on SP/SR and invited to attend a meeting to ask questions, find out more and potentially express an interest in participating in the SP/SR programme.

Participation in SP/SR was voluntary and following this process, a group of seven PWPs (all female) chose to take part in the programme. The practitioners who chose not to take part cited time or ongoing life events as the main reason for not taking part (Haarhoff, Thwaites, & Bennett-Levy, 2015).

Two participants failed to complete the programme due to life events. Initial participants had a mean post-PWP qualification experience of 2.57 years compared with a post-qualification experience of 2.6 years for the completers.

**Procedure**

In line with procedural recommendations for best practice in SP/SR implementation (Bennett-Levy et al., 2015), there was a pre-programme meeting at which the group made key decisions around the programme implementation. Participants chose to complete each module over 2 weeks rather than 1 to allow sufficient time to practice (one module was stretched to 3 weeks).

Participants were encouraged to read the module and implement the SP during the first week of the module. Initial postings to a Discussion Forum were to be made by the end of the first week. The second week of each module was dedicated to posting enquiries and comments on other reflections and sharing learning and application to clinical practice. Facilitators (three senior CBT therapists with an understanding of LI CBT) posted clarifications when required and occasionally asked further questions to promote a deepening of reflection on practice.

During the programme, there were two face-to-face group meetings of 90 min each (at Module 4 and Module 9), which were used to answer any questions and help troubleshoot any problems encountered (with a view to reducing dropout and maximising engagement).
All developed a personalised personal safeguard strategy (to be used in the event that SP/SR raised unexpected distress that required support—see Bennett-Levy et al., 2015) and were trained to access the online message board. The participants discussed boundaries and confidentiality, and unanimously voted to use their real names rather than anonymous names.

Materials: SP/SR Workbook

The workbook content is described module by module in Table 1 in the Results section. Some SP activities mapped directly onto interventions that PWP would utilise in their day-to-day clinical work with patients (e.g., developing problem statements, behavioural activation); whereas some were not within the LI remit and were clearly identified as personal development activities (e.g., using imagery to identify and strengthen “New Ways of Being”).

Measures

The following self-rated measures were used by participants to track their overall experience of the programme:

- A self-rating of engagement with the programme (using a 0–10 scale);
- Time spent on the programme each week (number of minutes);
- Belief ratings (personal and therapy related);
- Goal attainment (using a 0–100 scale); and
- Perceived skill ratings on specific self-chosen CBT items (relating to their “average” and “most difficult” patient within the week) using the Cognitive Therapist Self-Monitoring Scale (Thwaites, Freeston, Bennett-Levy, Cromarty, & Armstrong, 2003).

Results

Full datasets of all measures from the five completers are available. Space prevents the inclusion of all data, but common themes are identified in the first part of this section. Narrative comments representing the SRs of the participants are included. Descriptions of examples of the module activities and associated reflections are also outlined in order to provide a “flavour” of the experience of undertaking an SP/SR programme.

Differences in Engagement and Time Spent on SP/SR

As shown in Figure 1, participants spent varying amounts of time on each module. For Participants 1–3, this appears to become more consistent between Weeks 11 and 15, when each spent approximately 60 min/week on SP/SR. The later modules show further divergence, but with a general increase in time spent on SP/SR each week.

Figure 1 also displays the time Participant 3 spent on SP/SR each week, plotted against her perceived engagement in the programme. The upward trend on the engagement line shows greatly increased participation from around Week 9, but a decrease in time spent. During one of the modules, Participant 3 reflected on this:

Some modules in the course took less time, but led to a greater change. The tasks in these modules were more related to changing day to day thinking and so although I spent less time actively working through the booklet, I can say that I was thinking more about the SP/SR process through my daily life. In this way, even when I was not ‘doing SP/SR’ I was still very much engaged with it.

Figure 1 also shows Participant 2’s ratings of time and engagement. One of her module reflections below provides further detail on her engagement:

From the time I spent completing the modules I can see how hopeful I felt both before starting SP/SR and in maintaining my learning at the end, despite fluctuations in my engagement throughout. For me engagement was more challenging when I had time away from patients as I had less to reflect upon or when peers weren’t interacting with the blog so I felt less stimulated.

Initial Deskilling

An interesting trend noted from the data shows that some participants noticed an initial deskilling when starting SP/SR. Figure 2 shows how Participant 2 rated their skills in eliciting key cognitions. Initially starting with moderate scores, this participant recorded a drop in perceived skills at the time of starting SP/SR, particularly related to working with their most difficult patient. Throughout the SP/SR course, these scores gradually rose. During module reflections, Participant 2 stated:

I had felt encouraged through the process to spend more time looking at the interactions between thoughts and emotions with patients. I now feel able to do this in an individualised way and have more confidence using the five areas approach than simple ABC models. This, combined with more understanding of the difficulties in engaging in change, has helped to make my role feel much more helpful.

Other participants noted a less immediate deskilling, as shown by Participant 3 in Figure 2. Participant 3 rated her skills with regard to pacing and efficient use of time. Starting low, the perceived skill level rises shortly after starting SP/SR, before dropping for several weeks. The levels rise again briefly, but drop at around Week 13 before returning to higher levels. Participant 3 reflected that:

. . . on starting SP/SR, I initially felt a rush of confidence in my role. This however reduced as I was faced with ‘the other side’. This led me to want to do a lot more in sessions and my time was not used as effectively. As I went on, this experience repeated a few times as I learned new skills that I tried to ‘fit in’. I feel that through the course I was able to reconcile this with a recognition of what is important, and of doing one thing well, rather than doing everything.

CBT-Specific Skills

All participants rated their average level of perceived skills for patients in general over the past 7 days, and for their most
Applying the cognitive model,

Module 2

Identifying any repetitive triggers,

Module 4

Recording negative automatic

Module 3

Applying behavioural activation to

thoughts (NATs) related to the

themselves.

problem situation, and then

recognition of the impact of these

Module 5

Completing thought diaries to test out

their NATs then identifying thought

processes or biases and use Socratic

questioning to address the

problematic underlying processes.

Module 6

Reviewing individual goals, identified

“roadblocks” and problem solving to

identify and plan the implementation

of potential solutions.

Module 7

Identifying any repetitive triggers,

cognitions, emotions or behaviours

related to the problem.

Table 1 Workbook Module Content and Reflections

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<tr>
<th>Module and brief description of content</th>
<th>Main learning and development themes from shared reflections (on the Discussion Board)</th>
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<tr>
<td>Module 1 Completing initial measures, problem list and visual analogue scales</td>
<td>Common themes noted within reflections were that participants found the completion of the questionnaires “useful and insightful” in understanding why patients often want to “score between” or feel the need to qualify their scores. The act of putting problems on to paper was found to be particularly difficult: “Throughout the whole process I too kept thinking, ‘am I doing this right?’ ‘is this what everyone else is doing?’ which is probably what patients feel when we ask them to complete booklets, tasks, etc. Overall, found it really helpful and insightful and not sure why I put it off so long.” Reflections about the difficulty in rating thoughts were prevalent: “This definitely made me think about what some patients must feel when I casually ask them to tell me how much they believe a thought, or how strongly they experienced an emotion,” whereas for others, uncomfortable thoughts were evoked: “I found it more difficult having to look at my own work and the impact my own issues/beliefs could have in sessions”</td>
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<tr>
<td>Module 2 Applying the cognitive model, developing a problem statement, and identifying goals.</td>
<td>Common themes from this module were that there were a range of standard PWP tasks utilised within therapy without a full realisation of the impact of these upon patients and the time needed to fully complete these. One participant comment on goal setting: “The goals I found difficult, I had to put a lot of time and thought into it, this made me realise that this is something I should be putting more importance on with patients, rather than trying to squeeze it into an already full session.” Participants reflected upon the impact of gaining a more thorough understanding from the patient perspective: “I didn’t anticipate finding this difficult so it really showed me how important it is to really give the support to patients when doing this task,” suggesting that insight was gained into the impact of these practices upon their patients and areas that would be improved upon when delivering therapy: “As for working with patients, I do ask people what they hope to change—for goal setting purposes—but now I see how helpful it would be to incorporate their strengths in to the formulation. Hopefully, like them, I will feel a sense that their problem can change. I also can see now how allocating the time to goals gives them an importance.” Following this exercise, participants shared their insight into their own assumptions about BA, e.g., “I think I am guilty of thinking ‘they don’t need BA’, but that’s what I thought for myself and I got something from it.” They also reflected on how they would more skillfully introduce BA in future, e.g., “I will be describing BA more as an ‘experiment’ initially ‘let’s find out and see’, as my own experience proved that we really cannot predict what will come out of it.” There were also themes around the delivery of BA, e.g., “I will spend more time on the process of BA instead of trying to jump ahead” and it’s potential wider usefulness e.g. “It has provoked much thought beyond BA for depression and has helped me to recognise its plethora of uses.”</td>
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difficult patient. For most participants, there was greater change in skills in working with the most difficult patient in the week, compared with their work with patients in general.

Figure 3 shows agenda setting and adherence as rated by Participant 1. Although both show a general upward trend, this is more pronounced for her most difficult patient during the week. Prior to commencing SP/SR, Participant 1 rated her skill in this area at zero, but toward the end, she rated her skill at six for several weeks. Her rating for patients in general showed much less variance. Participant 1 reflected that:

> Very early on in SP/SR I noticed a change in how I viewed my difficult patients and making changes, not only in my perception of these patients but also how I worked with them, had a huge positive impact on sessions, both for myself and for the patient.

Figure 3 also shows Participant 1’s ratings for skill in giving feedback. Similarly, this showed variance in perceived skill between patients in general and the most difficult patient. Perception of skills in this area for the most difficult patient rose quickly in the initial 6 weeks of starting SP/SR, before dropping to a low level, perhaps a further example of deskilling. After Week 15, the scores returned to match those of the perceived skill of working with general patients, and remained that way until the end of the course.

**Personal Belief Change**

In Module 2, participants were asked to identify their goals for working through the SP/SR programme. Some participants chose to track their progress in these, as demonstrated by Participant 4’s ratings in Figure 3.

**Personal Behaviour Changes**

Participant 2 rated “How many times did you call yourself stupid this week?” Initially the variance was between 0 and 3, but after the half-way point, this did not go over one per week. Her module reflection detailed the change process around this:
Figure 1  Engagement and Time Spent on Self-Practice/Self-Reflection (SP/SR) Each Week.
I quickly learned how self-criticism affected my practice and my confidence around colleagues. By changing how I thought about my own competence and the quality of my work, I was able to see a reduction in the need to criticise myself. I hope that patients I see can benefit from this and ultimately receive a better service, as well as increase my own work satisfaction.

Participant 3 also tracked her perceived achievement of goals. Figure 4 shows a strong upward trend for two personal goals.

**Work-Related Belief Change**

Participant 5 mapped her belief in the thought “I am not as good as other PWP” as shown in Figure 5. She rated this belief on a 0–9 scale, ranging from 0 (not true) to 9 (completely true).

**Work-Related Behaviour Change**

Participant 3 also had a work-related goal, to speak up more in work settings. Figure 5 also shows that initially this started low, but reached 90% achieved toward the end of the course.
Mapped onto the same figure are the data derived from Participant 3’s visual analogue scale (VAS). The VAS was used three times during SP/SR, during Modules 1, 6 and 12. The VAS required participants to identify a belief and associated rating. Although no causation can be assumed, there is an inverse relationship shown between the belief that “people think I am not capable” and the behaviour of speaking up more. Participant 3 reflected on this:

I’m not sure what came first, whether positive experiences of speaking out led to a decrease in my belief, or if feeling more valued and capable led to more confidence in speaking out.

**Examples of Module Tasks and Associated Reflections**

The final section of the results provides a module-by-module description of the SP/SR activities undertaken and a brief summary of the main reflections for that module from the participants. The aim is to provide a detailed flavour of the module-by-module experience for the participants.

**Summary and Discussion**

Consistent with evidence from other groups of SP/SR participants such as CBT therapists in training (e.g., Chaddock et al., 2014) and highly experienced CBT therapists (e.g., Davis et al., 2014), the module reflections, participant ratings, and feedback provide preliminary support for SP/SR being an effective professional development strategy for experienced PWP. Given that LI CBT interventions are likely to be increasingly utilised worldwide because of the shortage of trained therapists in both resource-rich and resource-poor countries (Fairburn & Patel, 2014), these findings have implications in the context of post-training development for LI practitioners outside the IAPT programme and the UK.

There is evidence of self-rated belief change (personal and work-related), behaviour change and skill change. In particular, these clinicians are reporting changes in dealing with the most challenging patients—those who require flexibility and adaptations to ensure engagement and the successful implementation of LI interventions (Anderson et al., 2009; Saxon & Barkham, 2012). The reflections from each module support this finding, emphasising the fine-tuning and increased artistry in delivering LI interventions, and with greater attention to the process of change. This is an encouraging result, as it suggests that SP/SR is making a difference at the level of metacompetence in more experienced PWP (Thwaites et al., 2014), consistent with the results of a previous study in highly experienced CBT therapists (Davis et al., 2014).

Anecdotal reports suggest that the online message board and face-to-face meetings played an essential role in clarifying stuck points (e.g., application of learning to PWP role), developing group cohesion, reducing non-completion, and encouraging
participants to deepen their reflections and apply these to their clinical work.

Limitations of the Study

All participants were experienced PWPs and made an active decision to take part in SP/SR. A larger number of their fellow PWPs in the same service chose not to participate for a variety of reasons that are explored elsewhere (Haarhoff et al., 2015). The current study does not tell us whether similar positive findings would be achieved with a random sample of experienced PWPs or whether this is an artefact of the self-selection by PWPs who are motivated and already reflective.

In terms of measurement of outcomes, this study relied on participant self-report. Further research with objective measures of performance is required to provide stronger evidence.

Figure 4  Impact on Frequency of Behaviour.

Figure 4 illustrates the impact on frequency of behaviour for two participants: Participant 2 and Participant 3. The graphs show changes in frequency and percentage ratings before and during SP/SR. For Participant 2, the frequency count varies significantly, with peaks and troughs during the weeks of SP/SR. For Participant 3, the percentage ratings show changes in communication and openness with others and self-awareness.

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evidence regarding SP/SR as a competency-enhancing intervention for LI practitioners (e.g., session ratings, patient feedback).

Although there is evidence from both the Discussion Board reflections and self-ratings that PWPs used SP/SR to make significant changes in their behaviours and beliefs about themselves (changes that appear likely to prevent burnout and help maintain PWP resilience), future trials of SP/SR would benefit from explicitly measuring physical and psychological well-being, burnout, and resilience.

**Conclusion**

This pilot study provides promising data to suggest the value of SP/SR with LI practitioners. SP/SR may help LI practitioners enhance their skills, including metacompetencies, and also avoid
burnout. To paraphrase the classic quote, a PWP “can have twenty years of experience or one year of experience twenty times. What makes the difference? A key component is reflection” (Skovholt et al., 1997). This initial evidence suggests that SP/SR is a key intervention in facilitating reflection and enhancing reflective skills in PWPs.

**Key Points**

1. SP/SR is a targeted training strategy in which practitioners typically use an SP/SR workbook to practice CBT techniques on themselves and reflect on the experience.
2. Previous studies have demonstrated a range of positive outcomes in trainee CBT therapists and also highly experienced CBT therapists, e.g., improved procedural skills, therapeutic flexibility, and creativity; reflective skills; and beliefs relating to both the therapist self and personal self.
3. This is the first study to explore the impact of an SP/SR programme on the clinical competency of experienced PWPs.
4. The findings were consistent with previous research on other therapist populations and demonstrated perceived skill changes, increased flexibility, and artistry in the delivery of therapy and also changes in personal and therapist beliefs.
5. Key themes were also observed around the initial perceived deskilling of the practitioners during the early weeks of the programme and also the main benefits being for the most difficult and challenging patients.

**Note**

1. The authors of this article include a combination of experienced PWPs (LC, RL, LJ, AR, MT) and senior clinicians (RT) from within the same National Health Service IAPT service. The senior clinicians facilitated the SP/SR programme, and the PWPs completed the 24-week programme. All five programme completers were involved in writing up this paper.

**References**


