Counselling and Psychotherapy Research

WILEY

ORIGINAL ARTICLE

What if My Best Isn't Good Enough? A Phenomenological Exploration of Clinician Self-Doubt in Mental Health Practice

John Robert C. Rilveria

Department of Psychology, University of the Philippines Diliman, Quezon, Philippines

Correspondence: John Robert C. Rilveria (jcrilveria@up.edu.ph)

Received: 8 December 2025 | **Revised:** 11 March 2026 | **Accepted:** 8 April 2026

Keywords: clinicians | phenomenology | reflection | self-doubt | supervision

ABSTRACT

Introduction: Self-doubt is a pervasive yet often unspoken experience among mental health clinicians, manifesting as moments of uncertainty in which they question their ability to make sound clinical judgements, support therapeutic progress, or meet professional expectations. This study aimed to deepen understanding of self-doubt as a complex, nuanced, and meaningful aspect of clinical practice, exploring how it shapes clinicians' professional experience, decision-making, and personal growth.

Methods: Using descriptive phenomenology, the lived experiences of self-doubt among 12 Filipino licensed psychologists were examined. Data were collected through in-depth, semi-structured interviews and analysed using thematic analysis to capture the nuanced and contextualised experiences of participants.

Results: Analysis revealed five core themes: the *Inner Critic*, the *Contextual Triggers*, the *Demanding Pressure*, the *Double-Edged Sword*, and the *Reflective Space*. Findings indicate that self-doubt is not inherently detrimental; it can function as a regulatory mechanism that fosters humility, ethical sensitivity, and heightened self-awareness when approached with reflection, supervision, and self-compassion.

Conclusions: These findings suggest the potential value of creating supervisory, organisational, and peer contexts that acknowledge, normalise, and provide structured opportunities to reflect on experiences of professional self-doubt. While the present study draws on a small, context-specific sample, the phenomenologically grounded insights it offers may be relevant to considerations in clinical training, supervision, and organisational support systems.

1 | Introduction

Mental health clinicians are expected to embody competence, empathy, and insight. However, behind this professional expectation often lies a voice that asks a persistent question: *What if my best isn't good enough?*

One of the most endorsed personal challenges in psychotherapy is self-doubt among clinicians and clinicians-in-training (LaDonna et al. 2018; Thériault and Gazzola 2010). Self-doubt is defined as the state of uncertainty regarding one's ability and subsequent performance (Meehan 2019). This may stem from an interaction between one's judgement and appraisal of their roles and capacities on the one hand, and performance history and environmental consequences on the other. In psychotherapy, clinician self-doubt refers to uncertainty about one's ability to help a client, make clinical judgements, and facilitate therapeutic outcomes (Meehan 2019). This experience, when left unprocessed or when misinterpreted, may escalate and transform into self-perceived inadequacy, insecurity, incompetence (Thériault and

Summary

Implications for practice and policy

- Training programmes and clinical practice should adopt a developmental lens, acknowledging that self-doubt is not restricted to early-career clinicians. Interventions should provide ongoing reflective support across career stages, particularly during transitions such as moving into supervisory roles, working with high-risk populations, or navigating system-level constraints.
- Clinicians benefit from supervision that recognises the dynamic interplay between internal self-critique, situational triggers, and sociocultural expectations. Supervisors should tailor guidance not only to skill development but also to managing culturally-informed pressures and the emotional complexity of doubt.
- Clinicians should be supported in cultivating metacognitive awareness—recognising when doubt is facilitating ethical vigilance and reflective insight versus when it is maladaptive and paralysing. Structured exercises in supervision, peer consultation, or self-reflection can help clinicians differentiate "healthy" doubt from self-undermining patterns and transform it into a regulatory tool.
- Organisational policies that validate and normalise the experience of self-doubt should be developed, integrating supervision, reflective practice, and peer support into clinical workflows to support clinician well-being and sustain high-quality therapeutic care.

Gazzola 2010), self-criticism (Hill et al. 2007), self-depreciation (Thériault and Gazzola 2008), and imposter phenomenon (Clark et al. 2022; DeCandia Vitoria 2021).

Though self-doubt is a normal part of clinical practice, persistent doubt can lead to emotional exhaustion, reduced clinical efficacy, and burnout (Maslach and Leiter 2016). As mental health work involves emotionally complex, ethically sensitive, and often ambiguous situations, even seasoned clinicians experience periods of deep introspection, uncertainty, and vulnerability (Nissen-Lie et al. 2017). Research has shown that various events in psychotherapy trigger self-doubt among clinicians. This experience may arise when there is difficulty in establishing an alliance with clients (Strean 1993), when clients experience slow progress or lack of progress (Thériault and Gazzola 2006), when clients unexpectedly and prematurely terminate therapy (Kullgard et al. 2022), and when there is comparison with peers (Hutchins and Rainbolt 2017). Unfortunately, clinicians who are unable to resolve their self-doubt are prone to experience burnout (Hannigan et al. 2004) and depression (Mahoney 1997) and may ultimately give up on their professional careers (Thériault and Gazzola 2008).

Self-doubt in clinical practice is also shaped by a range of internal and external factors. First, clinicians, especially the early-career ones, frequently experience a mismatch between academic training and the unpredictability of real-world clinical work, leading to feelings of incompetence and disillusionment (Gee et al. 2022). Second, client cases involving suicidality, trauma, or lack of progress often trigger self-questioning about therapeutic effectiveness (Nissen-Lie et al. 2017). Third, clinicians with high levels of maladaptive perfectionism or self-criticism are more vulnerable to persistent self-doubt and burnout (Thomas and Bigatti 2020). Lastly, organisational and systemic stressors, such as high caseloads, time constraints, and lack of supervisory support, further intensify self-doubt, especially in under-resourced settings (Williams et al. 2020). Training cultures within mental health professions often emphasise performance, technical mastery, and the demonstration of competence, leaving limited space for openly discussing professional uncertainty or vulnerability (Thériault and Gazzola 2008, 2010). As a result, clinicians may struggle to reconcile their internal experiences of doubt with external expectations of confidence and expertise. In many ways, clinicians are socialised into a paradox: to be fully present for others while learning to suppress or downplay their own emotional responses (Tsamalidou and Tragantzopoulou 2025; Bartle-Haring et al. 2022).

Despite these insights, qualitative research that foregrounds clinicians' narratives of self-doubt remains limited. Most studies emphasise symptomatology or theoretical framing rather than lived experience. This gap underscores the importance of the current study, which seeks to centre the voices of clinicians as they reflect on and describe the origins, impact, and evolution of self-doubt within their work. Understanding how clinicians experience, make sense of, and respond to self-doubt, especially within the messy, real-world context of therapeutic work, requires more than standardised measures. It demands close attention to narrative, context, and lived emotional experience. Furthermore, although clinician self-doubt has been widely discussed in psychotherapy and supervision literature, it is experienced within particular cultural and relational contexts. In the Philippine setting, clinical practice unfolds within relational norms that emphasise interpersonal sensitivity, emotional composure, and responsibility toward others—values rooted in indigenous psychological concepts such as *kapwa* (shared identity), *pakikipagkapwa* (relational connectedness), and *pakikiramdam* (empathic attunement; Enriquez 1992; Pe-Pua and Marcelino 2000). These cultural orientations highlight the importance of relational attunement and mutual responsibility in social interactions, which may influence how clinicians perceive and respond to moments of uncertainty in therapeutic work. While such expectations do not determine how self-doubt is experienced, they may shape how clinicians interpret, regulate, and reflect upon professional uncertainty. Examining clinician self-doubt within this cultural context therefore provides a situated understanding of the phenomenon and offers a basis for considering how cultural expectations intersect with professional identity and reflective practice in psychotherapy.

2 | Research Objectives

The motivation for this research stems from the need to provide an honest and empathetic account of what it is like to live with self-doubt as a clinician. This study aims to explore the lived experiences of clinicians who encounter self-doubt in the context of mental health practice. Specifically, it seeks to understand how clinicians experience and articulate self-doubt, identify

the kinds of experiences that contribute to the emergence or intensification of self-doubt, examine how self-doubt influences clinicians' therapeutic work, decision-making processes, and professional identity, and investigate how clinicians navigate and make meaning of self-doubt, including the strategies they employ to manage it and the ways in which these strategies contribute to their personal and professional development. Through a phenomenological lens, the study seeks to deepen understanding of self-doubt as a complex, nuanced, and meaningful aspect of clinical life.

This study addresses a critical gap by exploring self-doubt as a pervasive yet understudied phenomenon in mental health practice. By understanding how clinicians experience and navigate self-doubt, the study contributes to the development of psychologically safe environments, more reflective supervision models, and support systems that can enhance professional well-being and ethical responsiveness. The findings can inform policies on clinician mental health, reduce stigma around vulnerability, and promote compassionate clinical cultures.

3 | Methodology

3.1 | Research Design

The study employed a descriptive phenomenological research design to investigate clinicians' lived experiences of self-doubt within the context of mental health practice. Descriptive phenomenology aims to capture the essence of a phenomenon as it is subjectively experienced, free from the researcher's assumptions or theoretical impositions (Giorgi 2012; Beck 2021). Because descriptive phenomenology emphasises rich first-person accounts and systematic reduction of presuppositions through bracketing, it offers a rigorous framework for accessing the nuanced, emotionally laden, and often private dimensions of clinicians' reflective life-worlds (Sundler et al. 2019). Through its focus on describing the invariant structure of a shared human experience, this approach provides the methodological grounding needed to illuminate the complexity, ambiguity, and transformative potential of self-doubt in therapeutic practice (Beck 2021).

3.2 | Participants

A total of 12 licensed mental health clinicians were purposively sampled to ensure diversity in clinical experience, therapeutic orientation, work settings, and demographic backgrounds. The following inclusion criteria were established: (a) professional licensure: participants must be Filipino licensed psychologists; (b) clinical experience: participants must have at least 2 years of post-licensure experience in psychotherapy to ensure adequate exposure to the complexities of clinical work; (c) practice setting: participants must be currently engaged in clinical practice in at least one of the following settings: private practice, school or university clinic, psychiatric hospital, community mental health centre, or non-government organisation; (d) relevant lived experience: participants must self-report having personally encountered or grappled with self-doubt related to their clinical work, ensuring experiential relevance to the research phenomenon; (e) willingness to participate: participants must be open to discussing their experiences in a semi-structured interview and willing to provide informed consent for audio recording and data use.

To maintain ethical rigour and avoid role conflict, the following individuals were excluded: (a) supervisory or collegial conflicts: clinicians who are currently being supervised by the researcher, have supervised the researcher, or maintain any hierarchical professional relationship that may compromise voluntariness or confidentiality; (b) allied mental health professionals outside scope: psychiatrists, counsellors, social workers, psychiatric nurses, and unlicensed practitioners, as the study focuses on licensed psychologists whose training includes psychotherapy and clinical assessment; (c) insufficient clinical exposure: clinicians with less than 2 years of clinical practice, as they may not have substantial experience with the complex situations that typically elicit professional self-doubt. There were no restrictions on the treatment modality or therapeutic orientation.

3.3 | Data Collection

Data were collected through in-depth, semi-structured interviews that lasted between 60 and 90 min. Interviews were conducted via Zoom, a secure video conferencing platform with end-to-end encryption, to ensure accessibility and participant safety. The interviews focused on eliciting rich descriptions of episodes of self-doubt, their contributing conditions, emotional impact, and meaning constructions, as well as the journey of living with and through self-doubt. Interviews were audio-recorded, transcribed verbatim, and analysed using the whole-part-whole procedure in descriptive phenomenology (Englander and Morley 2023). The interview guide is available in File S1. Participants provided informed consent before commencing the interview, and the study was reviewed and approved by the College of Social Sciences and Philosophy, University of the Philippines Diliman, Ethics Review Board (CSSPERB-2025-117).

3.4 | Participant Profiles

Participants were purposively sampled to capture variation in professional experience and practice settings. This variation was intended to enrich the phenomenological description of clinician self-doubt. All 12 participants completed a demographic information form, and Table 1 summarises their relevant characteristics. Participants ranged in age from 28 to 52 years ($M = 37$, SD = 6.94) and included five males (42%) and seven females (58%). All were trained in clinical or counselling psychology, holding either a master's degree or a PhD, and represented a range of therapeutic orientations (i.e., psychodynamic, cognitive-behavioural, humanistic-existential, emotion-focused, family/systems, eclectic/integrative). The clinicians were engaged in active psychotherapy practice, delivered either in a hybrid format ($n = 4$, 33%) or fully onsite ($n = 8$, 67%). They worked across diverse practice contexts, including government hospitals, non-government psychological service centres, university clinics, and private practice. Their years of clinical experience varied widely, ranging from 4 to 24 years, allowing for a heterogeneous sample that reflects different stages of professional development.

TABLE 1 | Participant demographic characteristics.

Clinician	Age	Sex	Education	Therapeutic orientation	Modality	Work setting	Years in practice
C1	28	M	MA Clinical Psychology	Cognitive-behavioural	Hybrid	Private practice	4
C2	35	F	MA Clinical Psychology	Emotion-focused	Onsite	University clinic	8
C3	37	F	PhD Clinical Psychology	Cognitive-behavioural	Onsite	University clinic	9
C4	31	F	MA Counselling Psychology	Cognitive-behavioural	Onsite	Government Hospital	6
C5	44	M	PhD Clinical Psychology	Eclectic/Integrative	Hybrid	University clinic	12
C6	40	M	PhD Clinical Psychology	Psycho-dynamic	Onsite	Non-government	16
C7	31	M	PhD Clinical Psychology	Cognitive-behavioural	Hybrid	Private practice	6
C8	29	F	MA Clinical Psychology	Eclectic/Integrative	Onsite	Government Hospital	5
C9	36	F	MA Clinical Psychology	Family/Systems	Onsite	Government Hospital	10
C10	52	F	PhD Clinical Psychology	Humanistic-existential	Hybrid	Non-government	24
C11	40	M	PhD Clinical Psychology	Family/Systems	Onsite	Non-government	15
C12	41	F	MA Clinical Psychology	Psycho-dynamic	Onsite	Private practice	14

3.5 | Data Analysis

Data analysis followed a descriptive phenomenological framework, beginning with the adoption of the phenomenological attitude, wherein the researcher engaged in bracketing to temporarily set aside prior assumptions, theoretical knowledge, and personal experiences related to clinician self-doubt. This stance allowed the analytic process to remain grounded in how the phenomenon was presented in participants' consciousness. Analysis proceeded with repeated readings of each interview transcript to obtain a holistic sense of the narrative before identifying meaningful segments within the text. These meaning units, derived directly from participants' descriptions, were then systematically transformed into more abstract psychological formulations, a step that translated everyday expressions into language that captured their underlying experiential and psychological significance. Following this, the transformed meaning units were clustered into thematic structures, reflecting convergences and divergences across accounts while ensuring themes remained faithful to participants' lifeworld experiences. A cross-theme synthesis was then conducted to integrate all thematic insights into an exhaustive description of the phenomenon, leading to the articulation of a general structural essence that captured the invariant qualities of clinicians' lived experiences of self-doubt. Consistent with phenomenological rigour, a summary of preliminary findings was returned to participants for member validation, allowing them to assess the accuracy and resonance of the synthesised structure and to refine the analysis where needed.

4 | Results

Through iterative thematic analysis of the interview transcripts, five interrelated themes were identified that capture the clinicians' lived experiences of self-doubt in therapeutic practice. These themes reflect the complex emotional, cognitive, and relational processes that shape how practitioners understand, manage, and make meaning of their doubts within the clinical encounter.

4.1 | Theme 1: The Inner Critic: Persistent Voices of Self-Doubt

Clinicians described an internal dialogue characterised by harsh self-evaluation and a persistent fear of not measuring up to personal or professional expectations. This inner critic often emerged in quiet moments after sessions, when clinicians replayed their interactions and questioned whether they

had responded adequately, missed something important, or unintentionally caused harm. Several participants noted that this critical voice felt immediate and automatic—an internal reaction that surfaced before they had the chance to fully process the session. One clinician shared, "Even after ten years of practice, I sometimes leave sessions thinking, 'Did I just make things worse?'" (C9). Another reflected, "Pagkatapos ng session, bigla ko na lang naiisip, 'Bakit ko ba sinabi' yon? Tama ba 'yun?' Parang bumabalik lahat sa isip ko" ["After the session, I suddenly find myself thinking, 'Why did I say that? Was that correct?'"] (C3). For many, these moments of self-scrutiny formed a recurring part of their clinical experience, shaping how they viewed their competence and their ability to care for clients well.

4.1.1 | Sub-Theme 1.1: Immediate Self-Questioning After Sessions

Clinicians described a spontaneous, often automatic "mental replay" that occurred immediately after client encounters. This involved revisiting key moments in the session, scrutinising their tone, timing, or decisions, and evaluating whether these contributed positively or negatively to the therapeutic process. One clinician noted, "Right after the session ends, I catch myself wondering, 'Was that the right thing to say?' even before I've stood up from my chair" (C5).

4.1.2 | Sub-Theme 1.2: Fear of Causing Harm

A prominent dimension of the inner critic involved a quiet but persistent fear of unintentionally harming clients. Clinicians worried that a misattuned response, a poorly phrased question, or a missed emotional cue might have deeper consequences. As one participant shared, "Minsan natatakot ako na baka may nasabi ako na masyadong mabigat para sa client, tapos iniisip ko nang paulit-ulit kung paano niya tinanggap' yon" ["Sometimes I fear that I may have said something too heavy for the client, and I keep replaying in my mind how they might have taken it."] (C7).

4.1.3 | Sub-Theme 1.3: Feelings of Inadequacy and Insecurity

Beyond immediate self-questioning and fears of causing harm, clinicians also described moments when self-doubt took the form of a deeper sense of personal inadequacy. These moments were characterised less by evaluating specific interventions and more by a broader insecurity about their competence as therapists. Participants spoke of feeling that they were not capable of helping the client as effectively as they hoped. This experience sometimes led to a temporary loss of confidence, where clinicians questioned their own readiness or suitability for the role. One clinician described this feeling: "Minsan pakiramdam ko hindi sapat yung ginagawa ko. May mga times na parang nawawala yung tiwala ko sa sarili ko bilang therapist." ["I sometimes feel like what I'm doing isn't enough. There are moments when I start losing confidence in myself as a therapist."] (C2).

4.2 | Theme 2: The Contextual Triggers: Situational Conditions That Intensify Self-Doubt

Clinicians described how particular clinical and evaluative situations intensified their self-doubt, often making the inner critic feel louder and more urgent. These triggering contexts were not random; rather, they arose in moments when the stakes felt higher, when client needs were more complex, or when performance evaluations felt heavier. Clinicians recalled that certain encounters, such as handling high-risk cases, sensing disconnection in the therapeutic alliance, or receiving critical feedback, made them question their competence more sharply than usual. Early-career practitioners, in particular, reported heightened vulnerability in situations that highlighted the contrast between their experience and that of their more seasoned colleagues. As one clinician noted, "I always felt like I was one mistake away from being found out as a fraud" (C12). Across accounts, these situations activated an intensified form of self-scrutiny that shaped how clinicians navigated their work and perceived their professional abilities.

4.2.1 | Sub-Theme 2.1: High-Stakes or High-Risk Cases Heighten Uncertainty

Clinicians consistently described working with clients experiencing severe distress, suicidality, chronic issues, or trauma as moments when self-doubt became especially pronounced. These cases carried a heightened sense of responsibility, leaving clinicians more acutely aware of the consequences of their decisions. One clinician expressed, "Whenever I work with high-risk clients, there's a part of me that keeps asking, 'Am I doing enough? Am I missing something important?'" (C4).

4.2.2 | Sub-Theme 2.2: Ruptures in the Therapeutic Alliance Intensify Self-Questioning

Moments of relational strain, such as client withdrawal, client-reported dissatisfaction, or emotional disengagement, were described as powerful triggers of insecurity. Clinicians noted that even minor shifts in a client's tone or behaviour could prompt worry about their effectiveness. As one participant shared, "Kapag napansin kong parang hindi na engaged si client, bigla kong iniisip kung may nagawa ba akong mali. Minsan isang comment lang niya, tapos parang gumuho' yung confidence ko." ["When I notice that the client seems less engaged, I immediately wonder if I did something wrong. Sometimes it only takes one comment from them and my confidence feels like it collapses."] (C6).

4.2.3 | Sub-Theme 2.3: Feedback, Evaluation, and Peer Comparison Stir Feelings of Inadequacy

Receiving feedback, whether in supervision, team discussions, or performance evaluations, often made clinicians more conscious of perceived shortcomings. Early-career practitioners highlighted how comparison with more experienced colleagues magnified doubts about their pace of learning or clinical intuition. One clinician described, "Kapag naririnig ko' yung

insights ng mas senior, naiisip ko, 'Buti pa sila, ang bilis nila makakita ng patterns.' Tapos ako, parang ang bagal ko. Doon tumataas 'yung self-doubt ko." ["When I hear the insights of senior clinicians, I think, 'They're so quick at seeing patterns.' And I feel so slow by comparison. That's when my self-doubt really increases."] (C1).

4.3 | Theme 3: The Demanding Pressure: Weight of Expectations in Clinical Encounter

Participants also described moments when their self-doubt was shaped by the professional expectations and internalised standards they brought into their clinical work. Many reflected on a felt pressure to conduct sessions competently, maintain therapeutic momentum, and respond effectively to clients' needs. When they perceived themselves as falling short of these expectations, they sometimes began to question their adequacy as therapists. One clinician said, "Sometimes it feels like I'm expected to know exactly what to do in every session. When I'm unsure or things don't go as planned, I start thinking that maybe I'm not doing my job well enough." (C9) These expectations were experienced as subtle, demanding pressures that influenced how they appraised their actions during and after sessions. Clinicians shared that these expectations, toward maintaining harmony, staying attuned to unspoken emotions, preserving composure, and meeting relational obligations, formed part of the embodied texture of their self-doubt.

4.3.1 | Sub-Theme 3.1: Pressure to Maintain Harmony and Avoid Discomfort

Clinicians reported a strong pull to keep interactions smooth, warm, and affirming. They described feeling responsible for keeping the therapeutic space light, flowing, and free from unnecessary tension. When sessions became heavy or emotionally charged, many clinicians immediately questioned whether they had caused the discomfort or failed to manage the moment appropriately. These pressures were experienced and described as external expectations embedded in their professional and relational contexts, shaping how they interpreted and responded to difficult or tense interactions. One clinician shared, "Kapag naramdaman kong bumigat ang session, parang expectation sa akin na ayusin ito agad, at agad akong may doubt kung may mali ako sa ginawa ko." ["When I feel the session getting heavy, I feel expected to immediately fix it, and I instantly doubt if I did something wrong."] (C3).

4.3.2 | Sub-Theme 3.2: Expectation of Heightened Attunement to Unspoken Emotional Cues

Participants also described feeling expected to be highly attuned to subtle emotional cues during sessions. They shared that they often monitored tone shifts, silences, and nonverbal expressions closely, anticipating what clients might need even when nothing explicit was said. When they were unable to sense or "read" what a client was feeling, some clinicians experienced immediate self-doubt, wondering whether they had missed something essential or failed to respond appropriately. They experienced this attunement as an external demand of the therapeutic role, one that required constant vigilance and emotional sensitivity. A clinician illustrated this experience: "Minsan hindi ko maramdaman kung ano kailangan niya, parang dapat na ma-sense ko ito agad, tapos bigla akong nagdududa kung may kulang sa akin." ["Sometimes I can't sense what the client needs; I feel expected to pick up on it, and then I suddenly doubt if something is lacking in me."] (C12).

4.3.3 | Sub-Theme 3.3: Expectation to Remain Composed and Relationally Responsive

Clinicians described feeling an unspoken expectation to remain composed, steady, and emotionally grounded regardless of how demanding or complex a session felt. Several noted that expressing uncertainty, fatigue, or emotional difficulty felt "not allowed," and when they struggled internally, they questioned whether this reflected inadequate professionalism. Others also described moments when setting boundaries, such as saying no to additional tasks or limiting emotional availability, evoked discomfort and self-questioning. These expectations were experienced as external relational pressures that shaped how they evaluated their own adequacy and reliability in clinical work. One clinician expressed this experience clearly: "Parang kailangan laging kaya mo... kahit pagod ka." ["It feels like you always have to manage... even when you're tired."] (C11).

4.4 | Theme 4: The Double-Edged Sword: Barrier and Catalyst for Growth

Self-doubt was described as both a hindrance and a motivator, an experience that simultaneously constrained and enabled professional development. On one hand, it constrained their work by provoking emotional exhaustion, second-guessing, hesitation in clinical decision-making, and occasional paralysis in asserting judgement. These moments of self-doubt could feel heavy and immobilising, particularly during complex cases or unexpected therapeutic challenges. On the other hand, participants noted that self-doubt also served as a catalyst for growth. It prompted heightened self-reflection, encouraged careful consideration of clinical decisions, and enhanced ethical sensitivity, motivating clinicians to be more conscientious and attentive to clients' needs. This duality, where self-doubt was simultaneously uncomfortable and instructive, was a recurring experience in their professional lives. One senior therapist captured this ambivalence explicitly, framing self-doubt as both a challenge and a guide: "Self-doubt can feel paralyzing at times, making me question every choice, but it also keeps me humble and attentive. I double-check, ask questions, and stay grounded—it pushes me to grow, even when it's uncomfortable." (C10).

4.4.1 | Sub-Theme 4.1: Hesitancy and Reduced Clinical Assertiveness

Some clinicians reported that self-doubt often manifested as hesitation or reluctance to intervene decisively, particularly in moments of clinical uncertainty. This hesitancy sometimes led to missed opportunities for therapeutic engagement or delayed

interventions, as clinicians second-guessed the appropriateness of their actions. Self-doubt in this context functioned as a barrier, limiting their ability to act confidently and constraining clinical judgement. For example, one participant reflected on this internal conflict, highlighting the way self-doubt restrained action: "Minsan hindi ako agad nagsasabi ng idea kasi iniisip ko, 'What if mali ito?' At minsan yung katahimikan na yun, parang nakakaapekto sa client." ["Sometimes I hold back on an idea because I keep thinking, 'What if it's wrong?' That silence can cost the client."] (C1). This quote illustrates how self-doubt can inhibit assertiveness, creating tension between wanting to act in the client's best interest and fearing potential error.

4.4.2 | Sub-Theme 4.3: Enhanced Ethical Sensitivity and Caution

Clinicians reported that self-doubt sometimes sharpened their ethical awareness, encouraging caution and deliberate decision-making. Doubt prompted them to slow down, double-check safety protocols, and ask clarifying questions, fostering conscientious practice. One clinician shared: "Kapag may doubt ako, napapabagal ako, chine-check ko safety plans, nagtatanong pa para klaro—mas gusto kong maging cautious kaysa may mamiss na important." ["Doubt makes me slow down and check safety plans, ask clarifying questions—I'd rather be cautious than miss something critical."] (C7).

4.5 | Theme 5: The Reflective Space: Coping and Transformation

Participants described a range of ways in which they engaged with self-doubt through reflective processes and supportive professional relationships. Rather than solely attempting to eliminate doubt, many clinicians spoke of learning to work with it through practices such as supervision, peer consultation, journaling, and mindful reflection. These reflective spaces—both relational and personal—allowed participants to examine moments of uncertainty, process emotional reactions, and reconsider their clinical decisions. Over time, several clinicians described a gradual shift in how they understood self-doubt, moving from viewing it primarily as a sign of inadequacy to recognising it as a cue for reflection, learning, and ongoing professional development. One clinician captured this shift succinctly: "Once I accepted that doubt was part of the job, I stopped fearing it. It became a teacher." (C9).

4.5.1 | Sub-Theme 5.1: Doubt as a Prompt for Reflective Practice

Several clinicians described self-doubt as a motivator for reflective practice, prompting them to examine interventions, revisit case notes, consult literature, or seek supervision. Doubt was experienced as a catalyst, guiding clinicians toward deeper professional insight and ongoing development of clinical reasoning and self-awareness. One clinician articulated this reflective use of doubt: "Pag nagdududa ako, yun ang cue ko para mag-journal o mag-supervision para ayusin kung saan ako nagkulang." ["When I doubt myself, that's when I journal or go to supervision to sort out where I fell short."] (C2).

4.5.2 | Sub-Theme 5.2: Personal Reflective Practices

Many clinicians also described individual reflective practices, such as journaling, mindfulness exercises, or reflective note-taking, as strategies to externalise and process self-critical thoughts. By documenting sessions, examining emotional reactions, or pausing for mindful reflection, they could observe their self-doubt from a more objective standpoint. This process often reduced rumination and promoted insight, allowing clinicians to integrate moments of doubt into their ongoing learning. One participant shared their reflective routine: "I journal after difficult sessions—I just write what happened and why I doubted myself." (C5).

4.5.3 | Sub-Theme 5.3: Supervision and Peer Reflection as Containing Spaces

Clinicians highlighted supervision and peer consultation as safe spaces where self-doubt could be articulated and explored without fear of judgement. These settings enabled them to express uncertainties, receive feedback, and consider alternative perspectives on challenging situations. Participants described this external validation as containing and normalising, helping them to distinguish between doubt as a natural professional experience and doubt as a reflection of incompetence. For instance, one clinician reflected on how supervision helped transform self-doubt into a learning opportunity: "Sa supervision, puwede kong sabihin yung bagay na ikinahihiya ko, at nagiging bagay na puwede naming pag-usapan together—hindi patunay na incompetent ako." ["In supervision, I can say the thing I'm ashamed of and it becomes something we can look at together, not a proof that I'm incompetent."] (C6).

4.5.4 | Sub-Theme 5.4: Reframing Doubt in Professional Identity Development

Over time, several clinicians reported a gradual shift in perspective, where self-doubt moved from being perceived solely as a threat to competence to being recognised as a catalyst for professional reflexivity. Doubt became integrated into their professional identity as a signal for reflection, learning, and ethical attentiveness rather than a marker of failure. Participants emphasised that this shift required repeated encounters with doubt, often supported by supervision, peer dialogue, or personal reflective work. A clinician described this transformative experience: "Over time, nakita ko na yung doubt ay tanda na nagle-learn ako, hindi na failure—iba na yung pananaw ko sa sarili ko bilang clinician." ["Over time I began to see doubt as a sign I'm learning, not failing—it changed how I think of myself as a clinician."] (C6).

4.6 | Cross-Theme Synthesis

While each of the five themes highlights a distinct aspect of clinicians' lived experiences of self-doubt, they are deeply

interconnected, forming a dynamic system in which internal, contextual, sociocultural, and reflective dimensions continuously interact. The *Inner Critic* (Theme 1) represents the enduring internal dialogue of inadequacy and insecurity, often emerging spontaneously after sessions or in response to perceived missteps. This internal voice sets the interpretive frame through which clinicians perceive and appraise their actions, making them particularly sensitive to *Contextual Triggers* (Theme 2), which are episodic, situational activators of doubt, such as challenging client encounters, difficult therapeutic alliances, or critical feedback. The interplay of these internal and situational pressures can intensify self-doubt, especially in the absence of adequate support or coping strategies. *Demanding Pressures* (Theme 3) function as role-based and relational expectations that form the background texture of clinical work. Clinicians described these pressures as arising from professional norms, relational obligations, and cultural values, including maintaining harmony, reading unspoken emotional cues, and preserving composure. These expectations amplify both the inner critical dialogue and the impact of situational triggers, shaping how clinicians interpret their performance and self-worth during and after sessions. The *Double-Edged Sword* (Theme 4) captures the paradoxical nature of self-doubt: it can constrain clinical assertiveness and induce emotional strain, yet simultaneously foster reflective practice, ethical vigilance, and professional growth. It reflects a dynamic nature of self-doubt in clinical practice, where the same experience can generate both vulnerability and opportunities for professional growth. Participants emphasised that self-doubt's effect depends less on its presence and more on how it is navigated. In this way, self-doubt can function as a regulatory and generative force rather than a purely negative experience. Finally, the *Reflective Space* (Theme 5) mediates the transformation of self-doubt from paralysing to productive. Supervision, peer consultation, and personal reflective practices provided containing environments where doubt could be articulated, explored, and normalised. Clinicians who accessed these spaces reported learning to reinterpret the *Inner Critic* and *Contextual Pressures* as signals for reflection and professional development rather than evidence of failure.

Taken together, these themes suggest that self-doubt in clinical practice exists along a spectrum—from destructive, internalised shame to generative, growth-promoting reflection. The tipping point appears contingent on the relationship clinicians cultivate with their doubt, influenced by both internal resources (e.g., self-regulation, professional identity) and external supports (e.g., supervisory guidance, collegial dialogue, organisational culture). This synthesis underscores that self-doubt is neither inherently pathological nor wholly adaptive; its impact is relational, context-dependent, and embedded within both personal and sociocultural dimensions of clinical work.

5 | Discussion

5.1 | Internal and Situational Dynamics

The findings align with existing literature on clinician self-doubt, highlighting the role of the *Inner Critic* (Theme 1) and *Contextual Triggers* (Theme 2) in shaping evaluative self-reflection (Thériault and Gazzola 2010; Nissen-Lie et al. 2017). Clinicians' persistent self-scrutiny, coupled with environmental stressors, such as challenging client cases or critical feedback, often intensified feelings of inadequacy. Yet, consistent with the *Double-Edged Sword* theme (Theme 4), these same experiences prompted reflection, ethical vigilance, and clinical humility, supporting prior research on the adaptive potential of "healthy doubt" in therapeutic practice (Nissen-Lie et al. 2017).

Importantly, the study situates this phenomenon within both temporal and relational contexts, as self-doubt fluctuates across sessions, client interactions, and professional experiences, suggesting that it is not a static trait but a dynamic, context-sensitive process. These findings challenge purely deficit-oriented interpretations of clinician self-doubt. Instead, self-doubt emerges as multidimensional, simultaneously reflecting vulnerability, sociocultural expectations, and potential for growth. The interplay between internal critique and situational triggers suggests that interventions should not aim solely to eradicate doubt but to facilitate reflective engagement, supervisory support, and structured peer dialogue, allowing clinicians to harness doubt as a constructive force rather than a source of chronic self-undermining. This approach foregrounds the relational and systemic factors that shape self-doubt, emphasising the need for culturally attuned frameworks in clinical training and professional development.

5.2 | Sociocultural Dimensions

A novel contribution of this study is the elucidation of *Demanding Pressures* (Theme 3) as sociocultural expectations in shaping clinician self-doubt. Participants reported implicit expectations to maintain relational harmony, attune to unspoken client emotions, and preserve composure—experiences resonant with Filipino cultural values. For example, the pressure to maintain harmony and avoid tension appeared to be tied to widely shared Filipino relational expectations that favour *magaan na pakikitungo* (ease in interaction) and *pakikisama* (harmonious relating), which participants seemed to carry into their therapeutic work. Furthermore, when they were unable to discern a client's unspoken needs, they experienced a momentary collapse of confidence. These accounts echo culturally familiar expectations around *pakikiramdam* (sensitive attunement) and relational awareness, which participants appeared to enact intuitively within therapy. Some also recounted difficulty setting boundaries, noting that asserting limits sometimes brought discomfort and self-doubt. These experiences mirror familiar cultural values around *pagpapakatatag* (showing strength) and relational obligation to model strength and resilience, which participants appeared to internalise in ways that shaped how they assessed their adequacy as clinicians. These externalised pressures interacted with the inner critic, amplifying doubt in a culturally situated manner. Unlike overt supervisory or organisational feedback, these expectations were often internalised and tacit, highlighting the importance of understanding self-doubt as embedded in sociocultural and relational contexts.

5.3 | Reflective and Growth-Oriented Responses

Accessing *Reflective Spaces* (Theme 5), through supervision, peer support, or personal reflective practices, emerged as a key mechanism for transforming self-doubt into constructive professional

growth. Clinicians described how structured reflection enabled them to reinterpret the *Inner Critic* and *Contextual Pressures*, fostering self-compassion, ethical attentiveness, and enhanced clinical decision-making. This aligns with literature emphasising reflective practice and supervision as protective factors against burnout and maladaptive self-criticism (Thériault and Gazzola 2008; Tsamalidou and Tragantzopoulou 2025).

Reflection did not merely reduce distress; it enabled clinicians to reframe the *Inner Critic* and *Contextual Pressures*, interpreting doubt as a sign of conscientiousness rather than incompetence. Through reflective practice, participants were able to cultivate self-compassion, acknowledging limitations while maintaining a commitment to ethical care. Moreover, reflective engagement appeared to facilitate metacognitive growth. Clinicians reported becoming more aware of habitual patterns of self-doubt, their triggers, and the relational and sociocultural contexts that amplified them. This enhanced awareness, in turn, promoted more deliberate, attuned interventions and improved the capacity to navigate clinical ambiguity.

These findings highlight that reflective practices function not only as coping strategies but as active agents of professional identity formation. By integrating self-doubt into ongoing reflexivity, clinicians transform vulnerability into an opportunity for growth, ethical vigilance, and relational attunement. This underscores the importance of creating and sustaining reflective structures in clinical training and practice, particularly in culturally nuanced contexts where external expectations—such as maintaining harmony or relational responsiveness—interact with internalised standards to shape the lived experience of self-doubt. In this way, reflection becomes both a buffer against burnout and a mechanism for professional maturation, emphasising the relational and culturally embedded nature of clinical self-development. This is consistent with the reflective-experiential approach to addressing self-doubt in clinical supervision (DeCandia Vitoria 2021).

5.4 | Implications for Practice and Training

The findings of this study offer lived-experience insights that could potentially inform clinical training, supervision, and ongoing professional development. First, the results may offer a direction for extending the developmental model of clinician growth proposed by Skovholt and Rønnestad (2003), which emphasises early-career vulnerability, by highlighting that self-doubt is not confined to the initial stages of practice. Rather, doubt can resurface at key career inflection points, such as transitioning into supervisory roles, engaging with new client populations, or navigating systemic constraints, underscoring the need to conceptualise self-doubt as a recurring, developmental challenge rather than a phase to be "outgrown." This reframing invites a shift from a purely performance-oriented model of competency to a developmental and reflective approach, in which doubt is recognised as a potential signal of conscientiousness and ethical engagement.

A central implication for training and supervision is the normalisation and scaffolding of discussions about doubt. Clinicians frequently reported experiencing shame, self-isolation, and fear of judgement when confronted with uncertainty, particularly in environments emphasising competence and stoicism. Supervisors and educators can mitigate these effects by modelling openness, acknowledging their own professional doubts, and creating structured spaces for reflection and emotional processing. This approach not only reduces stigma but also equips clinicians with metacognitive skills to manage internal evaluative processes and respond adaptively to moments of uncertainty.

The study also highlights the importance of peer connection and community in buffering the isolating impact of self-doubt. Non-judgmental peer consultation groups, reflective teams, and collaborative supervision were described as grounding experiences, allowing clinicians to share vulnerabilities, validate experiences, and collectively navigate professional challenges. Embedding these relational structures into training and workplace culture may offer opportunities to enhance psychological safety, encourage reflective dialogue, and support sustainable practice.

Finally, the findings suggest a transformative reframing of self-doubt: rather than viewing doubt as a deficit, it can be approached as an indicator of care, attentiveness, and professional responsibility. Embracing doubt as part of the reflective process enables clinicians to cultivate both competence and compassion, integrating uncertainty into their professional identity without being paralysed by it. As one participant noted, "My doubt tells me I'm paying attention. That I care enough to question whether I'm doing right by this person." (C6).

Taken together, these implications may invite further reflection regarding mental health practice cultures that honour clinicians' internal experiences alongside their technical competencies. By supporting reflective engagement with self-doubt, the field can foster more resilient, ethical, and compassionate practitioners, ultimately enhancing the depth and authenticity of therapeutic care.

6 | Conclusion

This study underscores that self-doubt among clinicians is not a weakness, but rather a marker of self-awareness, professional conscientiousness, and care. When acknowledged and supported, self-doubt can enhance clinical depth, empathy, and ethical rigour, serving as both a reflective tool and a catalyst for professional growth. The findings illuminate the complex emotional terrain of clinician self-doubt, framing it as a deeply human aspect of therapeutic engagement rather than a purely negative experience. This challenges deficit-based narratives and offers a more nuanced understanding of doubt as both a burden and a potential gateway to reflective practice and ethical vigilance.

Clinician self-doubt emerged as a dynamic, recurring phenomenon that evolves across career stages and contexts. Early-career practitioners often experience doubt as a byproduct of inexperience, while more seasoned clinicians report its resurfacing during moments of transition, ethical ambiguity, or systemic strain. These patterns highlight the cyclical nature of self-doubt,

emphasising the need for ongoing reflective practice, supervision, and supportive structures throughout the professional lifespan.

The findings of the study suggest several practice-sensitive implications for clinical training, supervision, and organisational support structures. By illuminating how clinicians experience and navigate self-doubt, the study offers phenomenologically grounded insights that may inform reflective supervision practices, peer consultation processes, and future research on professional vulnerability in mental health practice.

6.1 | Limitations

Several limitations should be considered when interpreting the findings of this study. First, the sample was composed of clinicians who voluntarily chose to participate, which may have introduced self-selection bias. These participants were likely more reflective, comfortable with introspection, or open to discussing experiences of self-doubt. As a result, the perspectives of clinicians for whom self-doubt is deeply stigmatised, unacknowledged, or distressing may be underrepresented, potentially limiting the diversity of experiences captured. Second, the qualitative, phenomenological design prioritises depth, context, and richness of lived experience over breadth. While this approach is well-suited for exploring the subjective and nuanced nature of self-doubt, it inherently limits the generalisability of findings to the broader population of mental health practitioners. Third, although the sample included variation in years of clinical experience and training background, the study was not designed to systematically compare these groups. Observations suggesting differences between earlier-career and more experienced clinicians should therefore be interpreted cautiously, as the sample size does not permit robust subgroup analysis. Lastly, the findings are situated within Filipino cultural and institutional contexts. Norms related to relational sensitivity, composure, and responsibility toward others may shape how clinicians experience and interpret self-doubt. While these insights may resonate with practitioners in other relationally oriented cultures, the transferability of the phenomenological structure described here to different cultural and institutional contexts remains an empirical question and should be approached with caution. Despite these limitations, the study offers valuable, in-depth insights into the phenomenology of clinician self-doubt, highlighting patterns and dynamics that can inform practice, supervision, and future research.

6.2 | Directions for Future Research

Future research should continue to explore clinician self-doubt as a multifaceted and contextually embedded phenomenon: (a) Comparative studies across diverse cultural and organisational contexts could illuminate how cultural scripts, professional norms, and institutional expectations shape the experience, expression, and management of self-doubt. Such work may clarify the ways in which sociocultural values influence the thresholds for adaptive versus maladaptive doubt, as well as the coping strategies clinicians employ; (b) Longitudinal designs would be particularly valuable in mapping the developmental trajectory of self-doubt across different career stages, from early training through senior or supervisory roles. Understanding how doubt emerges, recurs, or transforms over time could inform developmental models of clinician growth, highlighting critical periods for reflective support and professional scaffolding; (c) Quantitative investigations could examine the relationships between self-doubt and relevant professional outcomes, including clinician burnout, therapeutic alliance, treatment effectiveness, and supervisory engagement. This would provide empirical evidence for the potential consequences of both unresolved and effectively managed doubt; (d) Finally, intervention research is needed to evaluate the efficacy of targeted strategies—such as structured reflective practice, supervisory support, peer consultation groups, or mindfulness-based approaches—in transforming maladaptive self-doubt into adaptive professional engagement. Collectively, these research directions would deepen the field's understanding of clinician self-doubt, guide the development of culturally attuned training and supervision, and support sustainable professional practice in diverse mental health settings.

Overall, this study advocates for mental health systems and training programmes that normalise clinician vulnerability, scaffold reflective practice, and cultivate environments where doubt is recognised as a natural and potentially constructive component of professional growth. By embracing clinicians' inner experiences, the field can advance toward a more compassionate, sustainable, and ethically attuned model of care—one in which both practitioners and clients are supported to be fully human.

Funding

The author has nothing to report.

Ethics Statement

The study was reviewed and approved by the College of Social Sciences and Philosophy, University of the Philippines Diliman, Ethics Review Board (CSSPERB-2025-117).

Consent

All participants provided informed consent prior to participation in the study. They were informed of the study's purpose, procedures, potential risks and benefits, and their rights to confidentiality and to voluntary withdrawal at any time without penalty.

Conflicts of Interest

The author declares no conflicts of interest.

Data Availability Statement

Research data are not shared.

References

Bartle-Haring, S., A. Bryant, and R. Whiting. 2022. "Therapists' Confidence in Their Theory of Change and Outcomes." *Journal of Marital and Family Therapy* 48, no. 4: 1190–1205. https://doi.org/10.1111/jmft.12593.

Beck, C. 2021. "Amedeo Giorgi's Descriptive Phenomenological Methodology." In *Amedeo Giorgi's Descriptive Phenomenological Methodology*, 31–42. SAGE Publications, Inc. https://doi.org/10.4135/9781071909669.n9.

Clark, P., C. Holden, M. Russell, and H. Downs. 2022. "The Impostor Phenomenon in Mental Health Professionals: Relationships Among Compassion Fatigue, Burnout, and Compassion Satisfaction." *Contemporary Family Therapy* 44, no. 2: 185–197. https://doi.org/10.1007/s10591-021-09580-y.

DeCandia Vitoria, A. 2021. "Experiential Supervision: Healing Imposter Phenomenon From the Inside Out." *Clinical Supervisor* 40, no. 2: 200–217. https://doi.org/10.1080/07325223.2020.1830215.

Englander, M., and J. Morley. 2023. "Phenomenological Psychology and Qualitative Research." *Phenomenology and the Cognitive Sciences* 22, no. 1: 25–53. https://doi.org/10.1007/s11097-021-09781-8.

Enriquez, V. G. 1992. *From Colonial to Liberation Psychology: The Philippine Experience*. University of the Philippines Press.

Gee, D. G., K. A. DeYoung, K. A. McLaughlin, et al. 2022. "Training the Next Generation of Clinical Psychological Scientists: A Data-Driven Call to Action." *Annual Review of Clinical Psychology* 18: 43–70. https://doi.org/10.1146/annurev-clinpsy-081219-092500.

Giorgi, A. 2012. "The Descriptive Phenomenological Psychological Method." *Journal of Phenomenological Psychology* 43, no. 1: 3–12. https://doi.org/10.1163/156916212X632934.

Hannigan, B., D. Edwards, and P. Burnard. 2004. "Stress and Stress Management in Clinical Psychology: Findings From a Systematic Review." *Journal of Mental Health* 13, no. 3: 235–245. https://doi.org/10.1080/09638230410001700871.

Hill, C., C. Sullivan, S. Knox, and L. Schlosser. 2007. "Becoming Psychotherapists: Experiences of Novice Trainees in a Beginning Graduate Class." *Psychotherapy: Theory, Research, Practice, Training* 44: 434–449. https://doi.org/10.1037/0033-3204.44.4.434.

Hutchins, H. M., and H. Rainbolt. 2017. "What Triggers Imposter Phenomenon Among Academic Faculty? A Critical Incident Study Exploring Antecedents, Coping, and Development Opportunities." *Human Resource Development International* 20, no. 3: 194–214. https://doi.org/10.1080/13678868.2016.1248205.

Kullgard, N., R. Holmqvist, and G. Andersson. 2022. "Premature Dropout From Psychotherapy: Prevalence, Perceived Reasons, and Consequences as Rated by Clinicians." *Clinical Psychology in Europe* 4, no. 2: 1–16. https://doi.org/10.32872/cpe.6695.

LaDonna, K. A., S. Ginsburg, and C. Watling. 2018. "Rising to the Level of Your Incompetence: What Physicians' Self-Assessment of Their Performance Reveals About the Impostor Syndrome in Medicine." *Academic Medicine* 93, no. 5: 763–768. https://doi.org/10.1097/ACM.0000000000002046.

Mahoney, M. J. 1997. "Psychotherapists' Personal Problems and Self-Care Patterns." *Professional Psychology: Research and Practice* 28, no. 1: 14–16.

Maslach, C., and M. P. Leiter. 2016. "Understanding the Burnout Experience: Recent Research and Its Implications for Psychiatry." *World Psychiatry* 15, no. 2: 103–111. https://doi.org/10.1002/wps.20311.

Meehan, Z. M. 2019. "Therapist Self-Doubt When Facing Severe Psychopathology in Adolescent Males." Master's thesis, University of Northern Iowa. UNI ScholarWorks. https://scholarworks.uni.edu/etd/968/.

Nissen-Lie, H. A., M. H. Rønnestad, P. A. Høglend, et al. 2017. "Love Yourself as a Person, Doubt Yourself as a Therapist?" *Clinical Psychology & Psychotherapy* 24, no. 1: 48–60. https://doi.org/10.1002/cpp.1977.

Pe-Pua, R., and E. Marcelino. 2000. "Sikolohiyang Pilipino (Filipino psychology): A legacy of Virgilio G. Enriquez." *Asian Journal of Social Psychology* 3, no. 1: 49–71.

Skovholt, T. M., and M. H. Rønnestad. 2003. "Struggles of the Novice Counselor and Therapist." *Journal of Career Development* 30, no. 1: 45–58. https://doi.org/10.1023/A:1025125624919.

Strean, H. S. 1993. *Resolving Counterresistances in Psychotherapy*. Brunner/Mazel.

Sundler, A. J., E. Lindberg, C. Nilsson, and L. Palmér. 2019. "Qualitative Thematic Analysis Based on Descriptive Phenomenology." *Nursing Open* 6, no. 3: 733–739. https://doi.org/10.1002/nop2.275.

Thériault, A., and N. Gazzola. 2006. "What Are the Sources of Feelings of Incompetence in Experienced Therapists?" *Counselling Psychology Quarterly* 19, no. 4: 313–330. https://doi.org/10.1080/09515070601090113.

Thériault, A., and N. Gazzola. 2008. "Feelings of Incompetence Among Experienced Therapists: A Substantive Theory." *European Journal of Qualitative Research in Psychotherapy* 3: 19–29.

Thériault, A., and N. Gazzola. 2010. "Therapist Feelings of Incompetence and Suboptimal processes in Psychotherapy." *Journal of Contemporary Psychotherapy* 40: 233–243. https://doi.org/10.1007/s10879-010-9147-z.

Thomas, M., and S. Bigatti. 2020. "Perfectionism, Impostor Phenomenon, and Mental Health in Medicine: A Literature Review." *International Journal of Medical Education* 11: 201–213. https://doi.org/10.5116/ijme.5f54.c8f8.

Tsamalidou, A., and P. Tragantzopoulou. 2025. "From Doubt to Development: Professional Journeys of Novice CBT Therapists." *Behavioral Science* 15, no. 11: 1504. https://doi.org/10.3390/bs15111504.

Williams, A. M., B. Reed, M. M. Self, W. N. Robiner, and W. L. Ward. 2020. "Psychologists' Practices, Stressors, and Wellness in Academic Health Centers." *Journal of Clinical Psychology in Medical Settings* 27, no. 4: 818–829. https://doi.org/10.1007/s10880-019-09678-4.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** Phenomenological interview guide.