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Improving the Quality of Cognitive Behaviour Therapy Case Conceptualization: The Role of Self-Practice/Self-Reflection

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Background: CBT case conceptualization is considered to be a key competency. Prior to the publication in 2009 of Kuyken, Padesky and Dudley's book, little has been documented concerning methods for training conceptualization skills and the conceptualization process is usually perceived as predominantly an intellectual process. In this paper, the Declarative-Procedural-Reflective model of therapist skill acquisition provides a route to understanding how different kinds of knowledge systems can be integrated to enhance therapist skill acquisition. **Method:** Sixteen recent graduates of a postgraduate diploma in cognitive behaviour therapy worked independently through a self-practice/self-reflection workbook designed to lead them through a series of CBT interventions commonly used to elicit the information required for a CBT conceptualization. **Results:** The participants' self-reflections were thematically analyzed and uncovered the following inter-related themes: increased theoretical understanding of the CBT model, self-awareness, empathy, conceptualization of the therapeutic relationship, and adaptation of clinical interventions and practice. **Conclusions:** A tentative conclusion reached, based on the self-reflections of the participants, was that targeted self-practice/self-reflection enhanced case conceptualization skill by consolidating the Declarative, Procedural and Reflective systems important in therapist skill acquisition.

Keywords: Case conceptualization, self-practice, self-reflection, training.

Introduction

The evaluation of the effectiveness of Cognitive Behaviour Therapy (CBT) training programs, whilst recognized as important, has not been a focus of mainstream research in the field (Bennett-Levy, 2006). CBT training programs generally combine a theoretical and practical approach using the following methods: lectures, prescribed reading, clinical demonstrations, role-plays, supervision, experiential, and reflective practice (Bennett-Levy, McManus, Westling and Fennell, 2009). Earlier studies evaluated overall CBT competency after training (Milne, Baker, Blackburn, James and Reichfelt, 1999) using versions of the Cognitive Therapy Rating scale (Blackburn et al., 2001; Young and Beck, 1980). More recent studies have compared trainee assessment and supervisor assessment of overall competence (Bennett-Levy and Beedie, 2007; Mathieson, Barnfield and Beaumont, 2009), whilst others

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have employed questionnaires and reported trainees' perception of their competency after training (Kennedy-Merrick, Haarhoff, Stenhouse, Merrick and Kazantzis, 2008; Myles and Milne, 2004). Little published research has evaluated specific CBT competencies such as conceptual, interpersonal, or technical competency, the exception being a recent paper that investigated which training methods are appropriate for which competencies, relying once more on the self-report of trainees (Bennett-Levy et al., 2009).

In this paper, the acquisition of conceptualization knowledge is considered. Case conceptualization (CC) is a key competency in CBT (Beck, 2005; Dobson and Shaw, 1993; Padesky, 1996) and generally deemed an overarching psychotherapeutic competency (Eells, 2007; Eifert, 1996, Persons and Tompkins, 1997) providing the therapist with a roadmap to guide therapy. A CC of quality links theory, research, and practice, helping the therapist organize complex information systematically, providing information about suitable therapy interventions, making predictions about the nature of the therapeutic relationship, suitability for therapy, possible obstacles to therapy, protective factors, and resilience (Kuyken, Padesky and Dudley, 2009). For the purposes of this study the concept of CC includes gathering information about the client, written documentation of this, and sharing information collaboratively with the client. The CC is not something that occurs only at the start of therapy and guides clinical work thereafter, but a hypothetical working model of the client's difficulties that is updated through the course of therapy (Kuyken et al., 2009). When used in this way the CC process becomes central to the therapist maintaining empathy with the client, helping to define and adjust the therapeutic relationship, both at the start of therapy and as therapy progresses.

Does self-practice/self-reflection have a role?

Until recently little has been documented concerning specific methods for training clinicians in CC (Persons and Tompkins, 2007). These authors recommend that trainee clinicians should be familiar with theoretical models used for conceptualizing problems, and practice generating and applying hypotheses in situations where discussion and debate are encouraged. Knowledge of psychopathology, psychometrics, developmental psychology, behavioural assessment, and interviewing skills is recommended (Nezu, Nezu, Friedman and Hayes, 1997). Familiarity with models is dependent on didactic teaching, reading, and research. There is some research that shows that the quality of generic CC improved after a 2-hour training session (Kendjelic and Eells, 2007). There is however, little reference to the value of a more intuitive and personal understanding, and CC is on the whole perceived as a purely intellectual process. In a recently published text, however, Bennett-Levy's (2006) Declarative-Procedural-Reflective (DPR) model of therapist skill acquisition, as discussed later in this paper, has been adapted to provide a framework for understanding and teaching CC skills (Kuyken et al., 2009, p. 253), indicating a shift to emphasizing the more subtle kinds of interpersonal, relational knowledge. Overall, however, there seems to be a gap between the formally taught knowledge required for CC and the process of being able to apply concepts and ideas fluidly and appropriately to the individual. In some approaches, such as psychoanalysis, personal therapy is considered to provide the crucial link between intellectual knowledge and a more experientially based capacity to "understand" the client.

While CBT has not prioritized personal therapy for its practitioners, self-practice (SP: practising therapy interventions or techniques on self as therapist) and self-reflection

(SR: reflecting on the process) can be considered a variation of personal therapy and, from this perspective, might be used to develop CC skills. The DPR model (Bennett-Levy and Thwaites, 2007) of therapist skill development is outlined to contextualize the selection of SP/SR as a training method to enhance CC. The model integrates three systems of information processing. The Declarative system refers to learning factual information and results in "knowing that", for example, learning about the different CBT models. Second, the Procedural system is concerned with knowing *"how"* and "*when"* to apply the factual knowledge, translating the Declarative knowledge into practice. The Procedural system relies on an interaction between interpersonal perceptual skills, self-schema (beliefs about self, others, and the world that predate the individual's role as therapist), and "self-as-therapist schema" (influenced by experiences such as training, supervision, and experiences with clients). These cognitive systems influence the way in which therapeutic decision making proceeds. Although "self-as- therapist schema" will differ from "self-schema", there will be an overlap between the two systems, and the more awareness the clinician has regarding the way in which these two processing parts of the Procedural system interact, the more skilfully they are able to understand others through the mechanism of their own understanding. The Reflective system integrates Declarative and Procedural knowledge. It is a process "called into action by circumstances such as curiosity, a mismatch of expectations or therapeutic rupture" (Bennett-Levy et al., 2009, p. 582), which fosters an awareness of both the client's and the therapist's belief systems.

A well developed Reflective system helps the clinician to reflect on the information that they have about a client from a number of different perspectives (Bennett-Levy, 2006). The Reflective system then "returns" conclusions reached to the Declarative and Procedural systems, and the clinician's expertise is enhanced by the experiential knowledge built up through clinical experience, and SP/SR (Bennett-Levy and Thwaites, 2007). The Reflective component draws on rational and experiential knowledge (Epstein, 1994) to produce a meta-cognitive process described as a "deeper sense of knowing" (Bennett-Levy, 2002).

The development of Procedural knowledge and skill requires high levels of self awareness, which, it is argued, can only be achieved through SR. It follows therefore that structured SP/SR, as part of psychotherapy training, could potentially improve all the information processing systems described above, facilitating the integration of both the experiential and rational mind.

This paper uses qualitative data from a study investigating the relationship between CBT CC skills and a SR/SR intervention. The larger study objectively evaluated the content and quality of CBT CC produced by 26 novice CBT clinicians, who had graduated from a Postgraduate Diploma in CBT (Haarhoff, 2008). The CCs were evaluated using three rating scales. Participants, allocated to intervention and comparison groups, were required to produce four CCs based on clinical vignettes (two prior to, and two post SP/SR training intervention). Inferential analysis confirmed that, post SP/SR intervention, there was a significant difference in quality ratings, on the Fothergill and Kuyken Quality of Cognitive Therapy Case Formulation rating scale (Fothergill and Kuyken, 2002) in the direction of improvement in the intervention group. The rating scale consisted of a single rating that evaluated the psychological aspects of the conceptualization. The post intervention improvement did not hold for the other two scales, which were more generalized in their capture of information (Haarhoff, 2008). It could therefore be tentatively argued that increased understanding of the theoretical aspects of the CBT model was positively influenced by the

SP/SR workbook. In this paper, however, only the intervention group is discussed, and the focus is on how the SP/SR intervention was experienced by the participants.

Method

The intervention group ($n = 16$) completed a newly developed, manualized SP/SR training intervention in the form of a workbook entitled *Understanding Myself*. The thematic analysis of the reflections of the intervention group on the perceived impact of the SP/SR training intervention on CC competency is the focus of this paper.

Participants

Sixteen graduates from a Postgraduate Diploma of CBT were recruited as a convenience sample (6 males and 10 females). Demographics varied in terms of age, sex, professional/academic qualifications, clinical experience, employment setting, and hours spent per week doing CBT. Professions represented were psychologists, nurses, psychiatric registrars, social workers, occupational therapists, and counsellors employed in both public and private mental health settings. The average age was 44 years ($SD = 11$), with 9 years of experience ($SD = 7$), and 8 hours ($SD = 8$) spent doing CBT per week.

The workbook

The format of the workbook was influenced by a SP/SR workbook that investigated the impact of SP/SR on therapist skill acquisition in CBT trainees (Bennett-Levy, 2002). SP exercises, adapted from widely utilized sources (Beck, 1995; Greenberger and Padesky, 1995; Leahy, 2003), were alternated with SR questions. Examples of interventions were the Five-part model (Padesky and Mooney, 1990), and the thought record (Greenberger and Padesky, 1995). Participants were familiar with the interventions, and would have used them in clinical practice. The exercises were included to elicit personal cognitive and behavioural themes and provide participants with the information necessary to construct personal CBT CCs using the Judith Beck conceptualization worksheet (1995). In this study, CC refers to gathering of information about the presenting problems, and making explanatory sense of this in terms of other relevant information.

The CBT CC links cross situational core beliefs, underlying assumptions and compensatory behaviours with relevant early experience to provide a hypothetical explanation for a client's presenting problems. To reinforce the structural nature of the CBT model, the workbook had three sections, enabling the participant to experience levels of cognition in sequence, moving from surface to deeper levels of thought.

Section one contained three SP exercises, namely "understanding my problems" (Greenberger and Padesky, 1995, p. 13), the five-part model, and the thought record. In section two, negative automatic thoughts, underlying assumptions, and core beliefs were revised and underlying assumptions emphasized. The SP exercises required identifying recurrent cognitive themes from thought records, and then completing a worksheet identifying and linking underlying assumptions and behavioural themes. Finally, a worksheet was used to match underlying assumptions with repetitive compensatory behaviours and avoidance strategies. The third section contained seven SP exercises. Core beliefs were identified using the "downward arrow" technique (Greenberger and Padesky, 1995) on situations extracted

from the thought records that had generated high emotional intensity. The participant was then required to relate this information to the results of a series of questionnaires aimed at uncovering schema, compensatory behaviours, and avoidance patterns (Young and Brown, 1990; Young, 1995; Young and Rygh, 1994). The completion of the questionnaires was followed by a SP imagery exercise linking core beliefs to developmental origins, providing the predisposing component of the conceptualization. The final SP exercise required completing the Judith Beck (1995) CC form.

Examples of SR questions were: "Comment on how it felt to process your thoughts in this way?"; "Did this exercise give you any insights into yourself?"; and "Did you notice any themes that might relate to some of your underlying beliefs?"

Procedure

Participants were sent the workbook and asked to complete the alternative SP/SR worksheets and return their SRs to the first author within 3 weeks. Information about the importance of CC and the layout of the workbook was provided. Participants were asked to identify a recurrent problem related to current experience, causing moderate to high levels of emotional arousal. They were cautioned not to choose an acute, or trauma related issue. Participants then proceeded systematically through the exercises in the workbook.

Data analysis

The handwritten SR responses were returned and transcribed. Thematic analysis was used to uncover themes relating to the general question "What are the subjectively perceived effects of completing the SP/SR exercises on the participants' conceptualization competency?" Thematic analysis followed the sequence of steps proposed by Braun and Clark (2006). First familiarization to the data was achieved by repeated reading. The second step was to generate codes referring to aspects of the material relevant to the study. The SR exercises required responses to predetermined questions, making the analysis "theory" driven and themes extracted were influenced by the questions, many of which focused on CBT conceptualization. Where a number of participant reflections mirrored a theme, the number of participants is recorded. However, because the sample is small, and the process of constructing a CC idiosyncratic, the perspectives of single individuals has been included as offering insight into the range of experiences reported. The personal pronoun "she" was used to refer to all participants, and fictitious names distinguish between participants' SR.

Results

The following six interacting and overlapping SR themes were identified from the data: increased theoretical understanding of the CBT conceptual model; self-awareness; empathy; conceptualizing the therapeutic relationship; adaptation of clinical practice; and CBT interventions.

Making experiential sense of the theory underpinning the CBT conceptual model

Theoretical understanding of the CBT conceptual model was the most frequently recurring theme. All participants reported understanding the components of the CBT model more

clearly. Participant SRs showed enhanced understanding of the structural aspects of the CBT model, identifying and linking negative automatic thoughts, underlying assumptions, core beliefs, and compensatory behaviours. They understood processes were cyclical, maintaining the identified problems.

SP/SR was reported as helpful in solving problems and Mary noticed the predictable and cyclical nature of her thoughts, emotions, and behaviours reflecting:

> I don't learn from similar experiences all that well. That I tend to act like this without thinking and then reflect on how I should have responded afterwards.

Identifying repetitive cycles is a fundamental building block in developing individualized CBT CC. After participants had understood how their personal problem played out in a number of cross situational contexts using the five-part model, the "thought record" was completed to process the cognitive component of the problem. Eleven of the participants, (69%) found the thought record helpful in tackling the cognitive aspect of their identified problem.

> Very helpful in reconstructing alternative thoughts/balance. I sensed an immediate reduction in that I can feel pleasant thoughts as a result. (Barbara)

Susan, grasping the importance of the emotional content of the cycle reflected:

> I am more attuned to my emotions. I will be more attuned to my clients' emotions. I need to work more in line with CBT as an emotional experience rather than something coming mainly from the intellect.

Referring to the questions aimed at uncovering the "meaning" of the hot thought, Anita experienced the thought record helpful on two levels, personal and professional, implying that she would use similar questions in clinical practice:

> Yes definitely on two levels, self-help, but as learning what are helpful questions in the process.

Participants reported that it was the act of doing/experiencing the impact of the CBT interventions that enabled them to achieve a deeper understanding of the model.

> Getting to know myself better"/Increased self-awareness.

"Self-awareness" is defined as the "recognition of feeling as it happens" and "ongoing attention to one's internal states" (Goleman, 1996, p. 47). Self-awareness as a theme references these qualities, and refers to participants' ability to observe their thoughts, emotions, physiological, and behavioural reactions to identifiable triggers, and use self-awareness to reflect on their belief system, considering how these beliefs might impact on the therapeutic relationship. The development of insight is shown by the following quote:

> A valuable experience drawing all the material together and making sense. How it does make sense – lots of penny dropping, lots of head nods. (Angela)

After using the five-part model and thought record to understand the components of the problem, cognitive themes about self, others, and the world, underlying assumptions, and compensatory behaviours, and patterns of avoidance were identified. Two participants reported increased self-awareness of their underlying assumptions, core beliefs, and

compensatory behaviours describing how their problematic cycles worked, as illustrated below:

> I realize the extent of my anxiety that inhibits my ability to fully enjoy myself, blunts my humour and creativity at times. I seek approval, approval is important to me, what others think is vitally important. I fear rejection. Some of my compensatory behaviours e.g. wanting to know, checking, thinking of what could go wrong are not very useful and impede my performance in other areas. (Mary)

This quotation illustrates insightful SR, linking thoughts about others with the resultant compensatory behaviours and recognizing the negative consequences of these behaviours in the long term.

For some of the participants, identifying underlying structures through SP led them to broader conceptual perspective when considering their core beliefs.

> I already had a good understanding of my beliefs about "self" and "others". But I had not considered the "world" before. A realization that I consider the world to be harsh and dangerous. (Mei)

Others commented on the power and longevity of their underlying beliefs,

> A greater understanding about how powerful underlying drivers–schema are and how powerful long lasting core beliefs reside from childhood unresolved. (Helen)

Becoming sensitized to the ways in which compensatory behaviours are used when coping with anxiety was reflected upon:

> My thoughts are all about what could go wrong and how I might miss out on my goals if the worst scenario happened. My behaviours are designed to reassure myself. . . I seek as much additional information as possible as a way of absorbing my adrenalin and reassuring myself. . .it confirmed what I know, that I am anxious about many things. (Mary)

The third section focused on the deepest cognitive processes, with exercises aimed at identifying core beliefs. Schema questionnaires, a SP exercise matching schema with compensatory behaviours, and an imagery exercise designed to elicit relevant early memories and explain the underlying belief system were included. Opinion was divided regarding the helpfulness of the questionnaires, with some participants finding it a long, tedious, and even frightening process, while others experienced information gained as interesting and revealing.

> Enlightening completing the schema questionnaires *and* I enjoyed this part of the study the most as it gives me a sense of where I can challenge myself. Fits well with unrelenting standards. (Angela)

In some cases the increased self-awareness generated by the SP/SR led to self-acceptance, for example:

> I don't have to be perfect in every session of CBT I have with a person – pull myself down, be less on guard with a person, ask them for feedback as to how I am doing – accept mistakes I made – acknowledge them to the person – I'm human too. (Veronica)

For this participant the heightened self-awareness generated by the SP/SR led to her understanding what could be described as "burnout". She reflected:

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> I understand how it was I became depressed at work 2 years ago and had to take sick leave.

She related this incident to her core beliefs, which she was now able to understand, stating:

> I am glad they are fully exposed now (core beliefs) I don't have to try so hard as to stress myself up to do my work and be a little more caring of myself.

In this example, the self-awareness engendered by the SP/SR could have a protective function preventing professional burnout.

Overall increased self-awareness was seen to enhance understanding of CBT, and facilitate empathy, helping the participant understand what it might "be like" for the client, and in this way inform the CC.

Empathizing with my client

Empathy, described as "standing in the shoes of the client", is a key component in developing a successful therapeutic relationship (Beck, Rush, Shaw and Emery, 1979). Empathy is aligned to self-awareness, and in the therapeutic context should be more than sympathetic reassurance that the client is understood (Safran and Segal, 1996, p. 85). The following quote captures the quality of empathic understanding in therapy: "to learn to go down 'the path' with the patient, to see and experience the world from the patient's viewpoint, but then to able to return" (Leahy, 2001, p. 239).

Participants commented that their empathy for their clients had increased as a result of the SP/SR, and recognized this as a positive effect. They reported a connection with the distress clients experience when confronted with the strength and negative impact of their beliefs on their lives, and the difficulty involved in facing psychological change.

The quotes below mention the word "struggle" in connection with the participants' confrontation with their entrenched schema, implying that working with their own process has highlighted this aspect of therapy.

> I can relate to the difficulty and pain of people who have depression and anxiety disorders, low self esteem etc, from believing that their negative schemas say all there is to say about them (through a struggle with my own schema). (Veronica)

The courage involved in undertaking therapy was recognized:

> It reminded me of the bravery and difficulty in examining one's beliefs. (Helen)

Overall participants reported that increased empathy as a result of SP/SR would influence the way in which information for a CC would be obtained. The emotional impact of such commonly used interventions as the thought record, and assessment measures, such as the various schema questionnaires, was acknowledged. The tenacity of core beliefs was "personally felt", along with the pain, and difficulty of self-disclosure, and the uncovering of painful historical experience.

Conceptualizing the therapeutic relationship (therapist's perspective)

Conceptualizing the therapeutic relationship, acknowledging and understanding the therapist contribution, was a central theme. The following quote acknowledged that underlying beliefs could affect therapist expectations of clients.

> It reminds me that I cannot "fix" things nor should I try, I should step back, listen more and talk less to clients. It helps me process my frustration with some clients and realize that it is about me and not them. (Melissa)

This quotation embodies the "demanding standards" therapist schema (Leahy, 2001), describing the expectation that clients should change rapidly and meet the therapist's high standards. The insight gained through SR could encourage an appropriate therapy pace and foster a non-judgemental stance.

For others, identifying their own schema, assumptions, and compensatory behaviours was seen as assisting them in understanding how this might affect their relationships with their clients and the therapy process itself.

> By going into depth of what I do, especially in terms of my assumptions and compensatory behaviours, I will be able to understand my clients more fully. (Mary)

The quotes imply that SP/SR had impacted on clinical practice. The increased ability to self-monitor through SR and, through this, to regulate and adjust behaviour in the therapy session, was a specific effect noted. The quotation below demonstrates the ability to reflect on the therapeutic relationship, and consider the way in which underlying beliefs and attendant compensatory behaviours could directly impact on therapy.

> I will be aware of these areas and be mindful of them being activated if a client has the same tendency or similar compensatory strategies. I might be mindful of them in all my client relationships knowing I have a tendency to take care of client needs. If I think I'm doing all the work it could be a warning that my schema are activated. I will be mindful of where my responsibilities begin and end. (Diane)

In these examples, compensatory behaviours resulting from common "therapist schema", such as the tendency to do too much of the "work" in therapy, take too much responsibility for the patient's progress, and the need to be perfect, emerge. Having identified these patterns, participants resolved to do things differently and adapt their clinical practice.

How do I make CBT fit my clients' needs?

The SR exercises guided participants to reflect on the following question "Does what I have experienced through the SP/SR lead me towards altering, or doing something different in my clinical practice, especially as far as CBT CC is concerned?" Here participants reflected on the implications of their idiosyncratic patterns of belief and behaviour on their professional practice. Bronwyn found that she had:

> New insight around avoidance of new activities which will be exposed to other to evaluate – until I become confident in private.

and reflected on how she introduced new interventions:

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> How I introduce new things – lots of preparation, this may lead to inflexibility. Part of CBT is its flexibility – this demands some risk taking; this avoidance behaviour of mine may limit my own modelling of empiricism.

The SR highlighted the possible impact her compensatory behaviours may have on practice. In this case preparing well for a session would generally be seen as positive, but when viewed against the backdrop of a personal belief system stemming from some negative beliefs about self and others, she was able to consider this in a different light.

Adaptation of CBT interventions particularly regarding conceptualization

Finally, there were also some specific modifications in the way participants would use CBT interventions when eliciting the CBT CC. The following adaptations to CBT interventions were embedded in the SR narrative of participants: an increased awareness and sensitivity to communicating CBT principles, improved use of questions, allowing the client time to process new data, and the importance of obtaining feedback; these were noted as necessary in collaborative CC. Participants were able to see the significance of paying attention to these finer points through their experience in uncovering their personal CC. These skills could be considered part of Procedural knowledge and be used to sharpen interpersonal perceptual skills.

Veronica reflected on how her experience of filling out the questionnaires had affected her assessment of clients:

> I ask my clients to fill out these questionnaires as a matter of course. Now I realize they are very challenging to the person and there is a temptation to be less truthful about the answers because of the emotional pain of being exposed as how I really am. Last week an older client refused to fill out the Young Schema questionnaire. She was very anxious and became angry because looking at the questions made her feel more anxious –worse. We negotiated to look at the schema questionnaire later in therapy.

In this instance, personal confrontation with entrenched schema had induced an initial avoidant response because of the exposing nature of the exercise. Having experienced this, the participant was able to empathize with the client's response and accommodate it in her therapy plan.

The example shows that participants had become aware that clients may be cautious about disclosing significant information by reflecting on their own responses, and have been able to use this personal information constructively in therapy. The questionnaires designed to elicit information about core beliefs are an important part of the CC process, providing additional and confirmatory information. The adjustment reported above would therefore be a valuable addition to managing this part of the assessment process.

There appeared to be increased sensitivity regarding the appropriate time to introduce concepts or interventions to clients, for example:

> That beliefs are entrenched and it can take different levels of awareness to challenge their depth. Beliefs don't change overnight so get more feed back from clients when they experiment to change their thinking and behaviour. (Diane)

Historical information was accessed using an imagery SP exercise that aimed to connect the participants' most troubling core belief to childhood experience. Ten participants (63%) found it relatively easy to access historical information. One participant found it difficult to remember specific instances but recalled having experienced strong emotion reaction in childhood.

> Very difficult but there were events in my childhood when I was very anxious and overwhelmed by anxiety. I saw the world as a dangerous place; some of it was to do with leading a sheltered existence. (Mary)

She went on to express surprise at this fact and appeared to think deeply about it;

> I am surprised at how difficult it was to recall the anxiety making experiences in childhood. On reflection, familial influences, parental behaviour and my genetic makeup of shyness (possibly) have influenced me.

She concluded that the experience had influenced her practice thus:

> It has made me more sensitive to the connections between childhood experiences, the schema.

Experiencing the imagery exercise, although difficult to do at first, had increased her understanding of the importance of emotions when accessing important information about the origin of underlying beliefs, which is central to the CC process.

A number of participants stated that the manner in which they accessed historical information from clients had been influenced by their experience of SP, for example:

> Yes – to be aware they can be strongly affected by emotions around childhood memories – be gentle when taking information in person, and warn them if they are doing it themselves that emotions can be aroused. I would get them to approach the whole thing with curiosity and a sense of exploration rather than disappearing under a weight of unresolved emotions. (Sarah)

The final SP exercise integrated the SP/SR information to create a personal CC. All but one participant found this exercise useful and illuminating. Reflecting on how "doing" a personal CBT CC might affect practice, two participants reflected on the importance of using the CC in therapy, sharing it at the right time, and eliciting feedback.

Obtaining feedback from the client concerning how much they have understood about the process is important in constructing a collaborative, compassionate, explanatory CC. It is important that the client "owns" the CC, and recognizing the importance of feedback is crucial (Kuyken et al., 2009).

Jennifer reflected that before doing SP/SR she had tended to avoid sharing the CC:

> I have tended to avoid case conceptualization in the past or at least avoided sharing them with clients as they seemed a bit harsh, whereas in reality clients might enjoy/be interested in/relieved etc to understand themselves in this way.

Reflecting on the explanatory power of her personal CC fostered the realization that sharing the CC with the client is important. This experience had the potential to change her clinical practice. Sharing the CC is widely acknowledged to be important in effective delivery of CBT (Kuyken et al., 2009) and this participant would have been told this during her training; however only after doing it was she able to see the benefit, reflecting:

> I probably don't place enough emphasis on this (probably because doing mostly "organizational" work with lots of required reports) I will use this more as a means of underpinning therapy.

Other effects on practice relating to the sharing of the CC were:

> If there has been a change, it's around presenting the case conceptualization in a meaningful way that facilitates the client to make links between their current problems and how they are maintained by previous patterns. (Diane)

Two participants commented on how SP/SR had impacted on the way they thought about their practice within the context of working with others in community mental health reflecting.

> It reinforced the importance of providing not just a lip service of CBT. Mental health service demands e.g. waiting lists and pressure to treat and discharge clients, can I believe "short change" some clients of full treatment.

This demonstrates awareness of the complexity and richness of a full CBT treatment package based on an individualized CC, followed by recognizing that institutional barriers could potentially compromise a transfer of clinical skills.

Difficulties in making use of the SP/SR workbook

All participants reported positive learning experiences gained from the SP/SR workbook. However, a variety of difficulties such as the time involved, technical difficulties eliciting the different levels of thought, finding alternative evidence for negative thoughts when working alone, and the exposing nature of some of the exercises, were identified.

The quote below shows the confronting nature of the schema questionnaire:

> I found the Young schemas more difficult to fill out than the PBQ. They seemed to challenge me to think reflect deeper and I felt a little sad as they helped me see how my schema had affected my life. I wondered "Am I really as bad as that?" For example, my people pleasing, approval seeking and trying to impress behaviour compensate for the schema "I am of no worth, incompetent".

However the learning or self-awareness generated from this exercise was:

> How harsh I am on myself. I have let the thought of incompetence and my belief I am of no worth drive me through my life and I am sick of it.

All the reflections on the exposing nature of the exercises were positive, implying that the participants had experienced increased personal understanding and psychological growth as a result. Although experiencing some personal pain when doing the exercises, an overall response to the process was positive, concluding that personal and professional development was enhanced:

> Very useful, challenging to go through CBT interventions for oneself. Increases understanding and empathy for the client and their work. *and* Increased insights into my personal beliefs and related behaviours and how these limit my life, introduces the possibility of challenging and changing these.

Overall, the experience appears to have increased belief in the power of the CBT model and engendered a respect for the way in which the CC could be used within this.

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One participant reported confusion, and a number of negative emotional, somatic, and behavioural reactions to the SP/SR interventions, for example

> A reluctance to examine my own behaviour; Irritation, fatigue boredom, impatience; Some of the processes seemed ambiguous, complicated, difficult, but I got there; Anger, frustration, impatience.

She characterized this as "resistance" after completing the exercises on the thought record, and as she progressed through the SP exercises, accessing the deeper cognitive behavioural processes, the confusion seemed to intensify, as illustrated below:

> Wow, I've got a lot of compensatory behaviours, is that significant? *and* I am not sure that I know or can make any conclusions about the results that are meaningful or have currency for me.

This could be interpreted as a tendency to become emotionally avoidant when faced with exposure to problematic personal patterns. If this is the case there may be some cause for concern regarding the way in which she would process client's emotions

An impression gained is that Joan would have benefited from the opportunity to discuss her progress through the workbook with a peer, tutor, or supervisor. It would have been useful to have uncovered the evidence of "confusion" conveyed by the statements above during training, and gives support to the idea of including SP/SR as part of training.

Discussion

The themes described above resonate with themes uncovered in previous studies (Bennett-Levy et al., 2001; Bennett-Levy, Lee, Travers, Pohlman and Hamernik, 2003; Haarhoff and Stenhouse, 2004). The present study is differentiated by emphasis on the impact of SP/SR on CC competency. A hypothetical model illustrates the interaction between SP/SR and CBT CC competency (see Figure 1). The large central square houses six inter-related themes (theoretical understanding of the model, self-awareness, empathy, therapeutic relationship conceptualized, adaptation of clinical practice, and adaptation of CBT interventions). Arrows indicate the direction of the relationship. The reflective CBT conceptualization of the therapeutic relationship (therapist's view) occupies the pivotal position in the model. On the first level, self-awareness is central, as the most immediate result of the SP/SR. Self-awareness is reported to increase both theoretical understanding of the model (learning by doing) and empathy for the client (standing in the shoes of the client through SP). Each of these themes impacts on the participants' perceived conceptual understanding of the therapeutic relationship. Participants reported an increased awareness of how self-schema might impact on self-as-therapist schema.

Conceptualization of the therapeutic relationship in this manner was then seen as impacting on therapy practice (the way they "did" therapy), and how they would choose and use therapeutic interventions. The degree to which the therapist is able to understand the interpersonal, emotional, and behavioural impact of his, or her belief system, has been shown to interact with many different aspects of the therapeutic process, almost all of which occur in the interpersonal arena. Lack of self-awareness regarding these factors can have negative consequences for therapeutic outcome (Leahy, 2007; Rudd and Joiner, 1997; Young, Klosko and Weishaar, 2003). Participants reported that it was the act of "doing" or experiencing the impact of the CBT interventions that enabled them to achieve a deeper understanding of the CBT conceptual model.

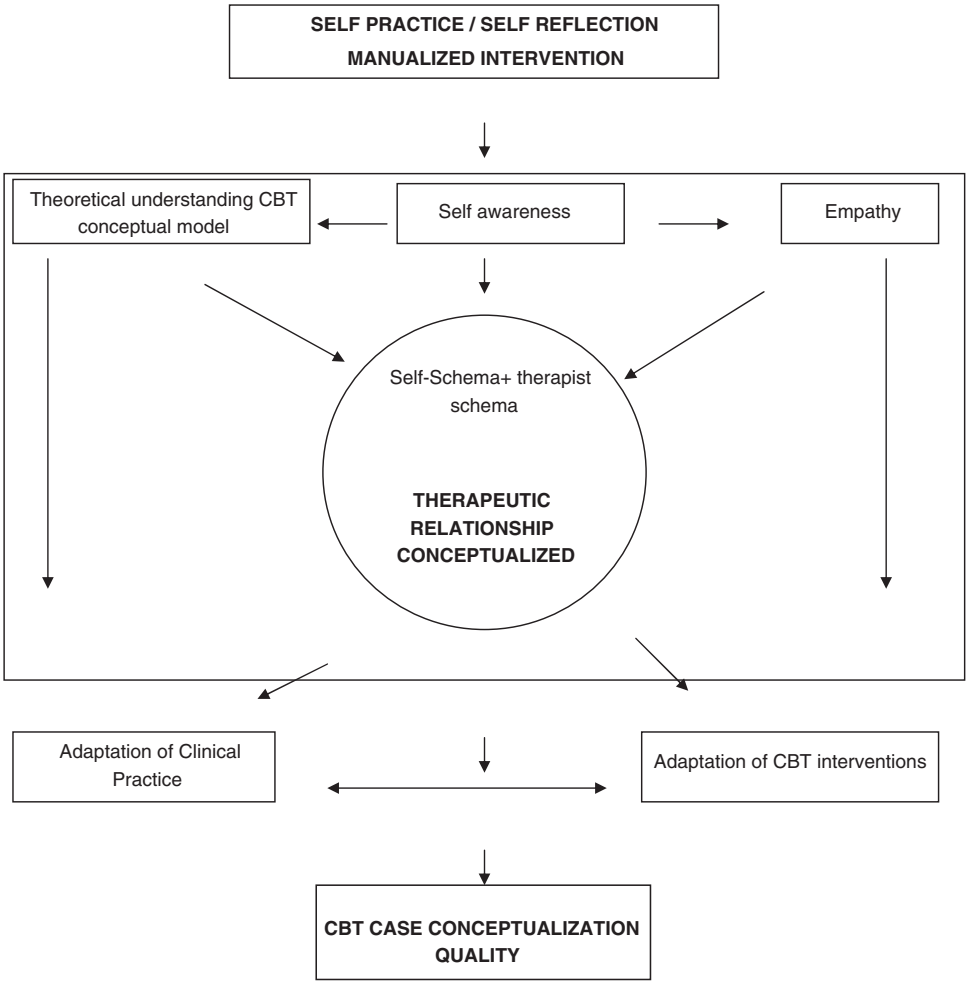

Figure 1. Interaction between self-practice/self-reflection and CBT case conceptualization quality

Facilitating the participants' personal understanding of the CBT conceptual model was the stated aim of the SP/SR intervention "Understanding Myself". The results of the thematic analysis suggest a tentative conclusion that the SP/SR process is useful in exercising all the components of the DPR model of therapist skill acquisition, and that the core competency CC, although often seen as a rational process reliant on Declarative knowledge, can be usefully augmented by Procedural knowledge gained through SP/SR.

Limitations

Sample size. The study required that participants were exposed to similar training experiences, thus limiting the number of suitable participants at the time of the research. These constraints

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meant that participants were drawn from different training cohorts, which may have influenced the results, in that some of the participants would have had a more recent experience of training and thus been more familiar with the material.

The SP/SR workbook: Understanding Myself. Although feedback from participants was positive concerning the benefits of completing the workbook, in hindsight, the research expectations were very high regarding, first, the amount of time participants were required to commit to the project and, second, the amount of emotional energy expended in an unsupported context.

The workbook was completed in isolation and not integrated into the training program or ongoing supervision. Although only one participant commented directly on this fact, we believe the potential utility of SP/SR could be more fully actualized as part of training and supervision if a dialogue concerning the experience could take place. The workbook is designed to be integrated as part of ongoing training where personal insights and difficulties can be constructively discussed, addressed, and incorporated with professional practice. Working in pairs or in small groups would also give additional support (Melanie Fennell: personal communication, 2009).

A recent paper documenting the use of shared reflective blogs as an SP/SR enhancement during training points to blogs serving as reinforcement and encouragement for trainees. These blogs helped establish a "learning community", which assisted the trainees to normalize and enhance their learning experience. The interactive nature of the blogs also improved supervision (Farrand, Perry and Linsley, 2010).

The disadvantages of reflection in isolation would apply particularly, to trainees experiencing difficulties such as those reported by Joan, who "got lost" and could find no relevance in some of the exercises. In cases such as this, one could speculate that, in addition to conceptual confusion, psychological processes such as emotional avoidance could have been a contributing factor. In this example, it is very likely that this participant would have benefited from support such as the interactive blogging described above.

Implications

The evaluation of training methods tailored to specific competencies in CBT is rare (Bennett-Levy et al., 2009). The present study supports the utilization of SP/SR in training and points to the way in which such methods can be helpful in training key competencies such as CC.

Participants reported that the SP/SR workbook consolidated, and in some instances increased, their theoretical understanding of the CBT conceptual model. Furthermore, enhanced self-awareness of the more subtle and complex aspects of the interplay between self and therapist schema on the collaborative conceptualization process was reported. Refinement of Procedural skill is flagged as differentiating experienced from novice practitioners (Bennett-Levy and Thwaites, 2007). The SP/SR workbook offers a structured, experiential approach that appears to enhance Declarative knowledge and Procedural skill, supplementing more traditional approaches to training, uniting some of the benefits of traditional personal therapy and experiential learning, with the more pragmatic and empirical orientation of CBT.

References

Beck, J. (1995). *Cognitive Therapy: basics and beyond.* New York: Guilford Press.

Beck, J. (2005). *Cognitive Therapy for Challenging Problems.* New York: Guilford Press.

Beck, A. T., Rush, A. J., Shaw, B. F. and Emery, G. (1979). *Cognitive Therapy of Depression.* New York: Guilford Press.

Bennett-Levy, J. (2002). *Cognitive Therapy in Three Dimensions: mapping the impact of self-practice and self-reflection (SP/SR) in the training of cognitive therapists*. Unpublished doctoral dissertation, Southern Cross University, Lismore, NSW Australia.

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

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

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

Bennett-Levy, J., McManus, F., Westling, B. and Fennell, M. (2009). Acquiring and refining CBT skills and competencies: which training methods are perceived to be the most effective? *Behavioural and Cognitive Psychotherapy, 37*, 571–583

Bennett-Levy, J. and Thwaites, R. (2007). Self and self-reflection in the therapeutic relationship: a conceptual map and practical strategies for the training, supervision and self-supervision of interpersonal skills. In P. Gilbert, and R. Leahy (Eds.), *The Therapeutic Relationship in the Cognitive Behavioural Psychotherapies* (pp. 255–281). London: Routledge.

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B. and Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy, 29*, 203–220.

Blackburn, I., James, I., Milne, D., Baker, C., Standart, S., Garland, A. and Reichelt, F. (2001). The revised Cognitive Therapy Scale (CTS-R): psychometric properties. *Behavioural and Cognitive Psychotherapy, 29*, 431–446.

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101.

Dobson, K. S. and Shaw, B. F. (1993). The training of cognitive therapists: what have we learned from treatment manuals. *Psychotherapy, 30*, 573–577.

Eells, T. (1997). *Handbook of Psychotherapy Case Formulation.* New York: Guilford Press.

Eells, T. D. (2007). *Handbook of Psychotherapy Case Formulation* (2nd ed.). New York: Guilford Press.

Eifert, G. H. (1996). More theory-driven and less diagnosis-based behaviour therapy. *Journal of Behaviour Therapy and Experimental Psychiatry, 27*, 75–86.

Epstein, S. (1994). Integration of the cognitive and the psychodynamic unconscious. *American Psychologist, 49*, 709–724.

Farrand, P., Perry, J. and Linsley, S. (2010). Enhancing self-practice/self-reflection (SP/SR) approach to cognitive behaviour training through the use of reflective blogs. *Behavioural and Cognitive Psychotherapy, 38*, 473–477.

Fothergill, C. and Kuyken, W. (2002). Quality of cognitive therapy case formulation rating-scale (Unpublished).

Goleman, D. (1996). *Emotional Intelligence*. London: Bloomsbury.

Greenberger, D. and Padesky, C. A. (1995). *Mind over Mood: a cognitive therapy treatment manual for clients.* New York: Guilford Press.

Haarhoff, B. (2008). *The Map, the Navigator, and the Explorer: evaluating the content and quality of CBT case conceptualizations and the role of self-practice/self-reflection as a training intervention*., Unpublished doctoral dissertation, Massey University, Auckland, New Zealand.

Haarhoff, B. A. and Stenhouse, L. M. (2004). Practice makes perfect: practicing cognitive behaviour therapy techniques and training. *New Zealand Clinical Psychologist, 4*, 26–30.

Kendjelic, E. and Eells, T. (2007). Generic psychotherapy case formulation training improves formulation quality. *Psychotherapy: Theory Research, Practice, Training. 44*, 66–77.

Kennedy-Merrick, S., Haarhoff, B., Stenhouse, L., Merrick, P. and Kazantzis, N. (2008). Training cognitive behaviour therapy practitioners in New Zealand: from university to clinical practice. *New Zealand Journal of Psychology, 37*, 8–17.

Kuyken, W., Padesky, C. and Dudley, R. (2009). *Collaborative Case Conceptualization.* New York: Guilford Press.

Leahy, R. (2001). *Overcoming Resistance in Cognitive Therapy.* New York: Guilford Press.

Leahy, R. (2003). *Cognitive Therapy Techniques: a practitioner's guide.* New York: Guilford Press.

Leahy, R. (2007). Schematic mismatch in the therapy relationship. In P. Gilbert and R. Leahy (Eds.), *The Therapeutic Relationship in the Cognitive Behavioural Psychotherapies* (pp. 229–254). London: Routledge.

Mathieson, F., Barnfield, T. and Beaumont, G. (2009). Are we as good as we think we are? Self-assessment versus other forms of assessment and competence in psychotherapy. *The Cognitive Behaviour Therapist, 2*, 43–50.

Milne, D. L., Baker, C., Blackburn, I. M., James, I. and Reichelt, K. (1999). Effectiveness of cognitive therapy training. *Journal of Behaviour Therapy and Experimental Psychiatry, 30*, 81–92.

Myles, P. J. and Milne, D. L. (2004). Outcome evaluation of a brief shared learning programme in cognitive behavioural therapy. *Behavioural and Cognitive Psychotherapy, 32*, 177–188.

Nezu, A., Nezu, C., Friedman, S. and Hayes, S. (1997). Case formulation in behavior therapy: problem solving and functional analytic strategies. In T. Eells (Ed.), *Handbook of Psychotherapy Case Formulation* (pp. 368–401.). New York: Guilford Press.

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

Padesky, C. A. and Mooney, K. A. (1990). Clinical tip presenting the cognitive model to clients. *International Cognitive Therapy Newsletter, 6*, 28–29.

Persons, J. and Tompkins, M. (1997). Cognitive-behavioral case formulation. In T. Eells (Ed.), *Handbook of Psychotherapy Case Formulation* (pp. 314–339.). New York: Guilford Press.

Persons, J. B. and Tompkins, M. A. (2007). Cognitive-behavioural case formulation. In Eells. T. (Ed.), *Handbook of Pychotherapy Case Formulation* (pp. 290–316). New York: Guilford Press.

Rudd, M. and Joiner, T. (1997). Countertransference and the therapeutic relationship: a cognitive perspective. *Journal of Cognitive Psychotherapy: An International Quarterly, 11*, 231–249.

Safran, J. and Segal, Z. (1996). *Interpersonal Process in Cognitive Therapy*. Northvale: Jason Aronson Inc.

Young, J. E. (1995). *Young Compensation Inventory*. New York: Cognitive Therapy Centre of New York.

Young, J. and Beck, A. T. (1980). *Cognitive Therapy Scale: Rating Manual.* Unpublished.

Young, J. E. and Brown, G. (1990). *Young Schema Questionnaire*. New York: Cognitive Therapy Centre of New York.

Young, J., Klosko, J. and Weishaar, M. (2003). *Schema Therapy: a practitioner's guide.* New York: Guilford Press.

Young, J. E. and Rygh, J. (1994). *Young-Rygh Avoidance Inventory*. New York: Cognitive Therapy Centre of New York.