Behavioural and Cognitive Psychotherapy, 2003, 31, 143–158
Printed in the United Kingdom DOI: 10.1017/S1352465803002029

COGNITIVE THERAPY FROM THE INSIDE: ENHANCING THERAPIST SKILLS THROUGH PRACTISING WHAT WE PREACH

James Bennett-Levy

Oxford Cognitive Therapy Centre, UK

Nicole Lee

Turning Point Alcohol and Drug Centre, Melbourne, Australia

Katrina Travers

Griffith University, Gold Coast, Australia

Sonja Pohlman and Elisabeth Hamernik

Prince Charles Hospital, Brisbane, Australia

Abstract. Experiential training and personal therapy have rich traditions in various therapies as strategies to enhance self-awareness and therapist skills. However, personal experiential work has not traditionally been part of cognitive therapy (CT) training. The purpose of the present study is to map the impact of personal experiential work on CT skills in a group of CT practitioners. Fourteen cognitive therapists undertook training courses utilizing a structured approach to self-practice of CT techniques, known as self-practice/self-reflection (SP/SR). Six therapists from one training group engaged in ''co-therapy'' sessions with a partner, while eight therapists from another training group practised CT techniques on their own. Both groups engaged in regular written reflections about their experience. Follow-up 1–5 months after the courses identified six areas of self-reported skill enhancement: Refinement of specific CT skills; Enriched communication of the conceptual framework of CT; Increased attention to the therapeutic relationship; Empathic attunement; Therapist self-reflection; and Therapeutic flexibility. The results suggested that SP/SR enhances the ''professional artistry'' of therapists, a finding consistent with literature suggesting that reflection is a key process in the development of therapist expertise. It is concluded that SP/SR represents a promising training strategy for cognitive therapists.

Keywords: Cognitive therapy training, experiential learning, self-reflection, therapist skills, adult learning.

Reprint requests to James Bennett-Levy, Oxford Cognitive Therapy Centre, Psychology Department, Warneford Hospital, Headington, Oxford OX3 7JX, UK. E-mail: james.bennett-levy@oxmhc-tr.nhs.uk

© 2003 British Association for Behavioural and Cognitive Psychotherapies

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

Introduction

Since the time of Freud (1937/1957), personal therapy and/or experiential work has been seen as an important component in the training of psychotherapists and counsellors. In many traditions of psychotherapy and counselling (e.g. Freudian psychoanalysis, Jungian analysis, transactional analysis, gestalt therapy), therapists-in-training undergo personal therapy (Macran & Shapiro, 1998; Williams, Coyle, & Lyons, 1999). In other traditions (e.g. family therapy, group therapy), personal experiential work (e.g. classroom work on family-of-origin experience) is included as part of training course exercises (Beck & Munson, 1988; Feiner, 1998; McDaniel & Landau-Stanton, 1991).

Despite the widespread use of personal therapy as a training device for psychotherapists and counsellors, there has been a paucity of studies evaluating its effectiveness. The empirical evidence that exists is weak. Therapists themselves rate the influence of personal therapy on their professional development very highly (Orlinsky, Botermans, Rønnestad et al., 2001). However, in a review of personal therapy for therapists, Macran and Shapiro (1998) suggested that while there was some evidence that personal therapy has a positive effect on empathy, warmth and genuineness, there was little other objective evidence of changes.

Methodological problems pervade the literature, and may partially account for the lack of relevant studies and useful findings. Not only is it difficult to determine whether any change of skill is the result of personal therapy, some other training process, or concurrent clinical experience – especially as personal therapy frequently lasts a considerable time – but also there is an embedded assumption that all personal therapists are competent, and all therapy is of value, which is unlikely to be true (Strupp, Butler, & Rosser, 1988). Furthermore, most of the personal therapy literature comes from one form of therapy, psychodynamic therapy. Only in the last few years is there any indication in the research literature of personal therapy with therapists from other therapy traditions e.g. humanistic, eclectic (Norcross, Dryden, & DeMichele, 1992; Williams et al., 1999).

Evidence for a positive impact of personal experiential work in therapist training courses is only marginally better. Perhaps the strongest evidence is provided by a meta-analytic review of three major counselling programs, suggesting that the program with a personal experiential component – Carkhuff's Human Resource Training/Human Resource Development – had the best outcomes (Baker, Daniels, & Greeley, 1990).

Behaviour therapy and cognitive therapy stand out as two psychological therapies that, in most countries, have not included personal experiential work as a requisite part of training (see Laireiter, 1998). With the advent of behaviour therapy, the practice of therapy was seen as a largely technological pursuit, and the value of personal development for the therapist was often de-emphasized (Gray, 1991). More recently, several leading cognitive therapists have suggested that practising CT techniques on oneself may make a valuable contribution to therapist training (Beck, 1995; Friedberg & Fidaleo, 1992; Linehan & McGhee, 1994; Padesky, 1996; Padesky & Greenberger, 1995; Safran & Muran, 2001). Padesky (1996, p. 288), for example, has written: ''To fully understand the process of the therapy, there is no substitute for using cognitive therapy methods on oneself.'' In part, acknowledgement of the value of personal experiential work may be a response to the growing recognition of the importance of interpersonal processes in CT (Safran & Segal, 1990), particularly in the context of working with more complex diagnostic groups e.g. personality disorders, substance abuse, bipolar disorder (Basco, 2000; Beck, Freeman, & Associates, 1990; Beck,

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

Wright, Newman, & Liese, 1993; Linehan, 1993). As Wills and Sanders (1997, p. 21) have stated, being a cognitive therapist now demands ''a high degree of self-knowledge – an awareness emphasised more readily in other therapies but now a necessary part of cognitive therapy.''

In an earlier study examining the impact of personal experiential work on the training of cognitive therapists, Bennett-Levy et al. (2001) devised a training strategy known as SP/SR (self-practice/self-reflection), based on the adult learning principles of experiential learning and self-reflection (Kolb, 1984; Schön, 1983; Boud, Keogh, & Walker, 1985). In SP/SR, trainees practise CT techniques on themselves (SP), either from workbooks on their own, or they do ''co-therapy'' with a training partner. Then they reflect in writing on the sessions (SR), looking at the implications for themselves, for their clients, and for cognitive theory.

Bennett-Levy et al. (2001) found that trainee cognitive therapists in a university clinical psychology program, using SP/SR, reported a ''deeper sense of knowing'' of CT practices. Participant reports suggested that SP/SR impacted at a conceptual level on therapeutic understandings, at a practical level on therapist skills, and at an attitudinal level on therapist self-concept. For many, the value of SP/SR was personal as well as professional. However, as Bennett-Levy et al. (2001, p. 214) noted, most of the data related to changes in therapist *understandings*, with only a limited amount on changes in therapists *skills*:

> The fact that less than 10% of the data referred to impact on therapist skills, or therapist self-concept, is not surprising. The course was only 13 weeks long, and the majority of trainees were doing their first clinical placements, and thus had little chance or context to gauge possible changes.

With novice trainees, since all aspects of CT are new – reading about theory, role-playing skills, observational learning via clinical demonstrations, SP/SR etc – it is reasonable to assume that the learning curve is steep, and that all teaching methods contribute in various ways to early skills development. When novice trainees comment on therapist skill development, it is extremely difficult to discern what proportion of the impact is caused by SP/SR, compared with other training techniques. However, the spontaneous comments of the more experienced therapists in the training program suggested that, amongst this group, it might be more possible to identify the specific impact of SP/SR on therapist skills, the assumption being that practitioners who have already learned basic therapy skills can more readily differentiate the impact of SP/SR from other learning processes.

Accordingly, the primary purpose of the study was to ''map the territory'': to determine *which* therapist skills may be affected by personal experiential work, in a group of practitioners who were already working professionally as cognitive therapists. ''Mapping'' was undertaken through a qualitative analysis of practitioners' self-reported changes in skill. No attempt has been made to measure actual changes in skill at this stage, since the present study, designed to identify the most relevant dimensions of SP/SR-induced change, is seen as the logical precursor to future skill measurement studies.

Method

Participants

The 14 participants whose observations have contributed to the present study were drawn from two different training groups: six were cognitive therapists from Brisbane (all female;

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

mean age = 38.3 years), who attended an SP/SR-based ''cognitive therapy experiential training group''; five had more than five years experience, and the other one had one-and-a-half years. The North Queensland group (NQ) were practising psychologists (seven female, one male; mean age = 34.5 years; 7 months to 7 years of experience), who were undertaking a one-semester course in CT within a university-based clinical psychology program.

The SP/SR courses

The Brisbane course was advertised on the e-mail lists of relevant professional bodies, and, following an introductory evening, eight people decided to participate. It comprised an introductory session, followed by five fortnightly workshops. Having made formal agreements regarding confidentiality, goals and course commitments, each participant engaged in a ''co-therapy'' relationship with a partner, focusing on a ''personal change project'' of low to moderate emotional intensity. At each workshop, partners engaged in both therapist and client roles, and reflected on the experience verbally at the end of sessions, and in writing between sessions. Therapy sessions were also undertaken during the alternative week to the workshop.

Each fortnight, participants e-mailed written reflections on their experience to the course facilitator, who then circulated them anonymously. A clear distinction was made between reflection on *process* and reflection on *content*; to preserve feeling of safety within the group, it was agreed that participants should only reflect on process.

SP/SR for the NQ group included the key ingredients of experiential learning and written reflection, but took a different form. Participants practised CT techniques on their own, using an SP/SR workbook designed by the first author. This utilized exercises from the client manual *Mind over mood* (Greenberger & Padesky, 1995) and followed them with specific reflective questions (e.g. what did you notice? what are the implications of your experience for your work with clients?). Participants e-mailed their reflections to the course coordinator, who then e-mailed back out to the group a weekly digest of the reflections with a brief commentary.

Methodological orientation

The present study is one of a series of studies designed to assess the experience and impact of SP/SR on practitioner development (Bennett-Levy et al., 2001; Bennett-Levy, 2003a). The research orientation has been founded on certain assumptions:

1. With the paucity of data and theory in this field, the aim of the research has been to develop a database, founded on the experience of practitioners, and to use an inductive approach to build theory methodically from the data.
2. Participants are in a unique position to comment on ways in which their experience has been impacted by personal experiential work. Formal measures (e.g. the Cognitive Therapy Scale, Young & Beck, 1980) may fail to pick up relevant dimensions of change (Milne, Claydon, Blackburn, & James, 2001; Whisman, 1993), and thus constrain data and theorizing.
3. There is a growing acceptance of qualitative methodologies within psychology (Banister, Burman, Parker, Taylor, & Tindall, 1994; Hayes, 1997; Richardson, 1996;

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

Smith, Harre, & Van Langenhove, 1995), and they have now reached a level of sophistication where verbal reports of participant experiences can be coded and classified in recognized, systematic ways.

4. The success of experiential learning programs (including SP/SR) is dependent on the development of trusting, engaged relationships between facilitator and participants (Robertson, 1996), and willingness to share experience. Hence, the traditional positivist detached relationship between researcher and ''the researched'' may often be unsympathetic to the context of SP/SR, unfeasible in practice, and pedagogically undesirable.

The research has been based on three qualitative methodologies: action research (Kemmis & McTaggart, 2000; Zuber-Skerritt, 1996), grounded theory (Glaser & Strauss, 1967; Pidgeon, 1996; Strauss & Corbin, 1994) and practitioner researcher self-study (Schön, 1983, 1987). Details of these are provided in Bennett-Levy et al. (2001) and the cited references. In brief, action research contributed the participatory, cooperative approach, and the cyclical process of the plan-act-observe-evaluate spiral, which structured the research process; grounded theory contributed the methodological framework and a systematic, rigorous set of methods to collect and analyse data; and practitioner-researcher self-study provided the focus on personal experience, and the reflective orientation of the study.

Research process

The Brisbane group was established with an explicit evaluative/research emphasis, based on action research principles. During the course, the principal research focus was on evaluation of automatic thought records and behavioural experiments as techniques for change (Bennett-Levy, 2003b). In meetings following the course, the present authors – four group members who wished to continue the research, and the facilitator – decided to evaluate formally the impact of SP/SR on therapist skills, since participants had noticed changes in their performance that they attributed to SP/SR.

Accordingly, three to five months after the course, the four Brisbane participant-researchers undertook two specific assessments to determine the impact of SP/SR on therapist skills:

1. They wrote a general reflection indicating the various ways in which they thought their therapy skills had changed as a result of SP/SR.
2. They closely observed a suggested 8–10 of their therapy sessions with clients, and noted immediately after the session the perceived differences in their skills (tapes were not used). Later, they formally wrote up these reflections, commenting on the differences; comparing them with the past; and linking them, where appropriate, with their SP/SR experience.

These two methods provided the data for the four Brisbane participants. Macran and Shapiro (1998) proposed similar methods to evaluate the impact of personal therapy on therapist skills.

In order to increase the size and representativeness of the sample, the data set was expanded to include every recorded written or spoken reflection in the Brisbane and NQ groups, which linked changes in therapy skills to the practice of SP/SR. Hence data were

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

included from two other members of the Brisbane group, who commented on skills changes during tape recorded group reflections during the course; and from eight practitioners in the NQ program, who had also made incidental comments about SP/SR-induced changes in skills in written reflections, or during interviews with the first author 4–6 weeks after course completion. Approximately 66% of the data (by word count) were contributed by the four Brisbane action researchers, who specifically focused their inquiry on the research question; the remaining data were contributed by the other 10 participants.

Data analysis

All relevant data were assembled and analysed as a group by the five authors, using the Technologies of Participation (ToP) workshop method (Spencer, 1989). The ToP workshop method provides a way for researchers to make group decisions about category naming and membership. Figure 1 illustrates the three-stage ToP process for forming category groups. One criticism sometimes levelled at qualitative methodologies is the potential for distorted, idiosyncratic interpretations, lacking credibility (Miles & Huberman, 1994). A particular strength of the ToP method is that it largely avoids these pitfalls, by demanding classification agreements across multiple researchers.

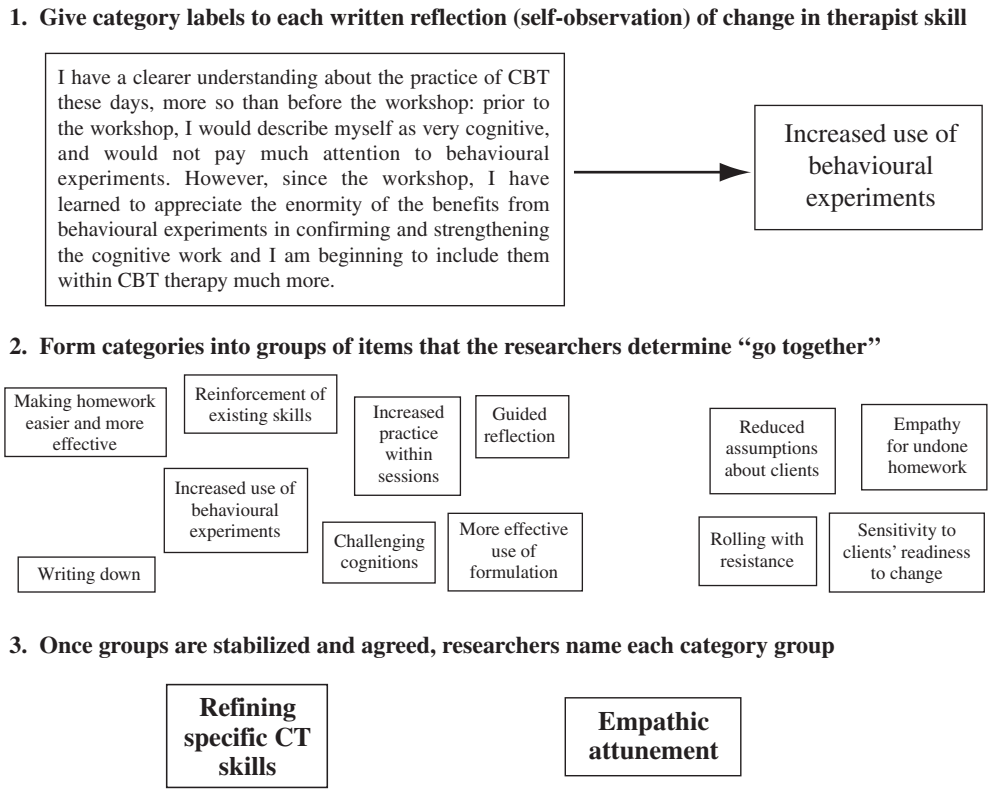


Figure 1. Technologies of participation data analytic method

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

The data reported in the Results section are directly derived from the ToP analysis. Although there were differences in data collection methods between the four Brisbane practitioner-researchers, who directly focused their reflections on the research question, and the other 10 participants, for whom these were incidental observations, the results were pooled as the type of observations appeared broadly similar. Specific similarities and differences between the groups are reported below.

Results

Changes in therapist skills formed six principal categories, and 22 subcategories. Only the principal categories are reported here. These were: (1) Refining specific CT skills; (2) Communicating the conceptual framework of CT; (3) Attention to the therapeutic relationship; (4) Empathic attunement; (5) Therapist self-reflection; and (6) Therapist flexibility. For each category, there were many examples, but for reasons of space just one illustrative example is given. All names have been changed to preserve anonymity.

Comparing the Brisbane and NQ groups, all 22 subcategories contained examples from the Brisbane therapists. The NQ group was represented in 16 subcategories: in all seven subcategories of (4), (5) and (6) above, 3/4 subcategories for (3), 5/8 subcategories for (1), and 1/3 subcategories for (2). Thus, while there was a large degree of overlap in the reported impact of SP/SR, the two groups appear to have differed to some degree in the extent to which they reported gains in the more specifically CT-oriented skills.

Refining specific cognitive therapy skills

Participants referred to a number of ways in which their technical CT skills had been refined through self-practice. The thrust of this refinement was towards making the delivery of CT more effective. Practitioners were using the formulation to greater effect by staying with it longer and using it to drive their selection of techniques. There was an increased focus on effective skills building for clients: existing skills were deliberately reinforced; homework was simplified, practised more within sessions, and anticipated difficulties prepared for more effectively. There was greater emphasis on behavioural experiments as a key component of therapy. The value of guided discovery and reflection, and testing and challenging cognitions, was reinforced, with an emphasis on the value of writing things down both in sessions and homework.

For instance, Sue recognized the value of self-reflection and guided discovery in her own SP/SR process, and noted how this had impacted on her therapy work:

> I think the main change for me is an increased awareness of the use of self-reflection as a therapy tool. I use much more socratic questioning and guided reflection with clients now and my focus is on teaching them to reflect on their behaviour, thoughts etc. I give them a lot more reflection for homework. I spend much more time (more sessions) on increasing awareness of cognitions through reflection on behaviour. I use guided discovery much more and I think I'm better at it because I think about it and use it deliberately.

Communicating the conceptual framework of cognitive therapy

The emphasis in this category was on *communicating* the conceptual framework of CT with the client more effectively: for example, explaining the cognitive model, sharing the

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

formulation, and conveying belief in the model. Participants alluded to such strategies as providing a stronger rationale for CT; taking more time to teach and explain the model; and ''selling the model'' better by providing more examples and showing greater enthusiasm and increased confidence in the possibility of change. An example is provided by Martina, who was running CT groups in her workplace, and had the following interaction in a group session:

> This session involved clients questioning the rationale of the CT model and ''Does it work?'' Normally I hate those questions – I always felt like a salesperson (and a shonky one at that). I think that feeling came from my own doubts of ''Well, all the evidence says it works but . . .'' – I am always much more convinced by personal experience. During this session, I now felt the confidence to relate that they really could expect changes. My own SP/SR experience really filled me with a renewed respect for the effectiveness of CT techniques and I think that enthusiasm and sincerity is evident to clients. No longer the shonky salesperson!

Increased attention to the therapeutic relationship

Participants noted changes, or a re-emphasis, on their relationship skills as a result of SP/SR. A sound therapeutic relationship was seen as creating the necessary basis for change. Being emphatic and collaborative, showing respect for courage and bravery, building rapport, being patient, and sometimes self-disclosing when appropriate were all areas in which participants judged that they had made often quite subtle, but important, changes. The experience of being ''in the client's shoes'' demonstrated starkly some of the anxiety and difficulties in making changes, even as high functioning individuals; and served to emphasize how valuable empathy, understanding, respect, tolerance and guidance of the therapist is.

Terri noted how her approach to the initial assessment interview had altered as a result of her SP/SR experience:

> I tend to let the client lead the talk (i.e. run with the client's agenda) and I get what I need from the conversation, rather than running the interview like a structured interview . . . I have found that running the interview like a conversation helps the rapport building of the relationship. In the past, I was much more structured in my initial interview techniques. The experience of being a client in the SP/SR process helped me to realize this. I found the initial interviews very ''hard'' as a client as you are describing problems that you may not be proud of, and to have a therapist ask questions that were seemingly unrelated would, I feel, damage rapport building. However, if I had the freedom to speak of my issues, with only occasional prompts, it gave the impression the therapist was more interested in ME, rather than getting a thorough history.

Empathic attunement

As a result of SP/SR, participants reported that they had greater acceptance of ''where the client was at'', and adapted their skills and strategies accordingly. They were more sensitive to the client's readiness or lack of readiness to change; they made fewer assumptions about the client's level of knowledge or skills, and checked these out or gave simple explanations before proceeding; their empathy for homework non-compliance was increased substantially as a result of their own experience; and they ''rolled with resistance'' in various ways –

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

for instance, by making use of ''failures'' in therapy, being more accepting of apparent resistance, and reinterpreting the meaning of resistance.

Jane noted that she had changed her attitude and response to homework non-compliance as a result of her experience of SP/SR:

> The other effect this exercise had for me was that I am more understanding of clients not doing their homework because I wasn't very good with it either and by the second week had a really hard time keeping up with the writing of thoughts. Somehow behavioural experiments seem a bit easier to complete than homework and so, I guess I changed what I give clients as homework too. If they don't record thoughts by the third session, the homework is behavioural and that seems to work pretty well. I give behavioural experiments as homework earlier in therapy.

Therapist self-reflection

SP/SR enhanced therapist self-reflection, both during sessions (reflection-in-action) and after sessions (reflection-on-action). During sessions, some therapists reported that they were more aware of their own internal process, and two of them commented that this increased awareness enabled them to increase the separation between their own process and that of the client, allowing them to be more objective in their response. After sessions, therapists were more inclined to use self-reflection as a self-initiated learning tool to improve their therapy skills.

For Eve, who was still in her first year working professionally as a therapist, reflecting systematically on a therapy session was a new skill:

> I also think, an important skill I have learned is self-reflection, for two reasons. One, for myself as a psychologist, to learn to look more into the therapeutic relationship and reflect on my sessions. Was my client trying to convey something to me through affect or something they said? Did I pick up on things that happened/were said in the session? I don't think I ever really did this before; I think I just assumed that therapy would work like a well-oiled machine. I plan the session, deliver the session – client leaves. I think I wrongly assumed that everything I did and taught my client would automatically work. How wrong was I!! This has definitely showed me to be more sensitive to what is happening within the session and to direct my attention to it.

Therapist flexibility

A number of practitioners commented that they were more flexible and adaptable in their use of CT techniques, and more inclined to experiment as a result of their SP/SR. For example, Henry said in his interview:

> You lose this rigid thinking in therapy that you are not even aware of. With the self-reflection you start to dig deeper and then you realize that slight changes can have different results and you are more willing to experiment with clients and take it on a deeper level and you get more self-confidence by testing it out on yourself. And really it's like you can know something very well and it works but once you have applied it to yourself it has got a different meaning and you lose these pre-conceived ideas ''if I do this, this should happen''.

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

> And with cognitive therapy I lost being afraid, if things don't work out, I have to change everything . . . Now I am actually using what happened in the data, and going from here, which is so much more beneficial to my health I think than having to come up with a completely new idea.

Discussion

The research presented here indicates that CT practitioners who undertake focused personal experiential work within a training context report an enhancement of their therapeutic skills in specific areas. These changes appear to be qualitative, as much as quantitative, the result of a perspective shift that comes from being ''in the client's shoes''. For instance, experiencing from the inside both the anxiety and the impact of behavioural experiments prompts therapists to ensure that clients are adequately prepared for experiments (Communicating the conceptual framework of CT); to monitor the client's emotional state closely, and establish appropriately graduated tasks (Empathic attunement); and often to put more emphasis on behavioural experiments (Refining specific CT skills) as a key component of therapy than they have in the past. These are not necessarily new skills for experienced therapists, but the client's shoes perspective creates an enhanced empathy and sensitivity for the client's situation, which results in a more careful approach to therapy, attuned to the subtle nuances of situations.

SP/SR participants appear to develop a more ''lived theory'' of CT, and a more elaborated ''theory of the client'' and ''theory of the therapist''. Their lived theory tends to promote use of their own language, their own metaphors, and sometimes their own experiences to illustrate relevant points (Attention to the therapeutic relationship, Communicating the conceptual framework of CT). Their theory of the client is felt from the inside. They have an inner appreciation of how a client may feel or think when having to make changes (Empathic attunement); they may reconceptualize the nature of ''resistance'', invoking a broader social and interpersonal context (the client is not just being ''difficult''); they understand better the nature of pain, the difficulty of change, and the nature of courage. Their theory of the therapist now encompasses a richer appreciation of the value of the therapist and the roles that therapists play, from guidance and skills development through to exploratory questioning and encouragement to extend beyond the comfort zone (Attention to the therapeutic relationship, Therapeutic flexibility). In short, the development of a more subtle appreciation and sensitivity to client ''in-process states'' (Greenberg & Goldman, 1988), and greater awareness of contextual factors through SP/SR, seems to prompt therapists to refine their repertoire of skills, and increase flexibility, tailoring their interventions more precisely to particular contexts.

The therapist skills data also indicate that SP/SR leads to the development of a valuable meta-cognitive skill for therapists, therapist self-reflection. As Wills and Sanders (1997) and others have pointed out, therapist self-awareness is becoming increasingly important for cognitive therapists in the context of working with clients with long-standing complex problems (Beck et al., 1990; Linehan, 1993). As a meta-cognitive skill within the clinical context, it enables therapists to reflect-on-action (after sessions) and to reflect-in-action (during sessions) (Schön, 1983, 1987), develops their perceptual skills (Greenberg & Goldman, 1988; Rice & Greenberg, 1984), and cultivates an attitude of mindful practice (Epstein, 1999; Safran & Muran, 2000).

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

Schön's (1983, 1987) work on competence in the professions has made a distinction between two kinds of knowledge: rational-technical knowledge, and what he terms ''professional artistry''. This distinction may be helpful in conceptualizing the effects of SP/SR. He suggested that while rational-technical knowledge may be acquired through traditional teaching techniques such as didactic learning, professional artistry is acquired through reflection.

A similar point has been made by Skovholt and Rønnestad in a series of studies of therapist development (Skovholt, 2001; Skovholt & Rønnestad, 1992; Skovholt, Rønnestad, & Jennings, 1997). They found that ''continuous professional reflection'' is a key component in the development of therapeutic competence. Over the last 20 years, adult educationalists have consistently emphasized the importance of experiential learning and self-reflection in adult learning (Kolb, 1984; Boud et al., 1985; Schön, 1987). One of the conclusions from the present study is that these processes are also central to the development of ''professional artistry'' (Schön, 1983, 1987) amongst therapists, enabling them to fine-tune their therapy skills. In essence, reflective practice is what distinguishes the expert therapist from the average therapist, and SP/SR directly facilitates this.

Therapists undertaking SP/SR in pairs (Brisbane), and on their own (NQ), reported broadly similar changes in skills, especially in the non-specific categories.[1] However, there are indications in the data that suggest that changes in the CT-specific skills (Refining specific CT skills, and Communicating the conceptual framework of CT) may be greater in the pairs group. We hypothesize that this is because, for the pairs, there is the added component of being in the therapist's chair, which enables perceptions from the client's chair about the value of the therapeutic relationship to be integrated with the actual *delivery* of the specific CT skills to a ''real life'' client. It is not that new CT skills are learned; it is that the existing ones are delivered with greater artistry, especially in the pairs group.

Are the results reported here consistent with the literature in the adjacent areas of personal therapy for therapists, and experiential training? The most consistent finding across both literatures is that personal experience with therapy techniques enhances empathy for clients (Beck & Munson, 1988; Greenberg & Goldman, 1988; Macran & Shapiro, 1998; McDaniel & Landau-Stanton, 1991; Norcross et al., 1992; Rennie, Brewster, & Toukmanian, 1985), with the assumption that interpersonal and perceptual skills in therapy are thereby enhanced. In the present study, enhanced empathy was a common denominator underpinning changes in a number of categories (e.g. Empathic attunement, Communicating the conceptual framework of CT, Attention to the therapeutic relationship).

Williams et al.'s (1999) study of personal therapy for therapists suggested that personal development, understanding the working alliance and understanding the therapeutic process are three of the principal gains, which were clearly mirrored in the current research. Norcross et al.'s (1992) list of the 10 most lasting lessons of therapy included: change is gradual and painful, albeit possible; there is need for patience and tolerance; therapist competence/

[1] Since the paper was submitted, we have found a book chapter (Laireiter, 1998), referring to German research – only published in German language journals – on ''self-experience'' of behaviour therapy and cognitive-behavioural therapy. According to Laireiter (1998), participants in these studies reported ''an improvement of their interpersonal skills and a higher empathy for and a better understanding of their clients'' and ''higher self-awareness and self-reflection''. Furthermore, participants *and* clients reported ''a higher interpersonal sensitivity and better client-therapist relationship'' after a weekend self-experience workshop. These data appear highly consistent with some of the categories from the present research.

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

commitment and use of self in therapy are important. These also have clear parallels in the present study, as do most of the items on their list.

The present research on SP/SR may be regarded as more systematic and detailed than previous research on either the impact of experiential training, or personal therapy for therapists. However, there are enough parallels to indicate that there is a close correspondence between the findings here and adjacent literatures.

A further issue concerns the value of the learning. Are the skills that participants suggest are enhanced by SP/SR those that are known to be important determinants of outcome from CT? Table 1 summarizes some of the relationships between the therapist skills categories, and skills that have been associated in the research literature with good therapeutic outcomes (Albert, 1997; Burns & Auerbach, 1996; DeRubeis & Feeley, 1990; Fennell & Teasdale, 1987; Hollon, Shelton, & Davis, 1993; Illardi & Craighead, 1994; Keijsers, Schaap, & Hoggduin, 2000; Kingdon, Tyrer, Seivewright, Ferguson, & Murphy, 1996; Skovholt et al., 1997).

As may be seen from Table 1, five of the categories of therapist skills (Refining CT skills, Communication of the conceptual framework, Therapeutic flexibility, Attention to the therapeutic relationship, Empathic attunement) map readily onto precisely those factors that are associated with good outcomes in CT and other therapies, while the sixth (Therapist self-reflection) has been identified as a key component in the development of therapist competence (Skovholt & Rønnestad, 1992). It is therefore concluded that the kinds of changes reported by participants undertaking SP/SR are those that research studies have identified as central to the development of competent and effective therapists.

Of course, any conclusions about the value of SP/SR need to be tempered by the fact that all the data are based on self-report, and there are no objective measures of therapist performance. For example, therapists may report that they are more tolerant and understanding of their clients when they do not do their homework, or that they are better able to communicate the cognitive model to clients, but this has not been measured, and it is not known how stable any such changes might be. These are clearly questions that need answering, but

Table 1. Therapist skills enhanced by SP/SR are associated with good therapy outcomes

Therapist skills enhanced by SP/SR	Therapist skills associated with good outcome in cognitive and other therapies
1. Refining specific CT skills	• Therapist expertise • Therapist adherence to model
2. Communicating the conceptual framework of CT	• Providing good rationale • Enhancing credibility
3. Increased attention to the therapeutic relationship	• Working alliance • Relational skills (Rogerian)
4. Empathic attunement	• Perceptual skills • Therapeutic empathy
5. Therapist self-reflection	• Continuous self-reflection
6. Therapist flexibility	• Therapist flexibility

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

are not the purpose of the present research. Here the purpose has been to map SP/SR-induced changes in therapist skills, as perceived by participants, which may then be used to generate hypotheses for future outcome studies using objective criteria.

A second area of caution is that two-thirds of the data were contributed by the four Brisbane participant-researchers, who undertook a systematic review of their changes in therapist skills; this is a high percentage of data from a small number of people. When compared with data from the NQ therapists, subcategory membership was very similar for four out of six categories, despite differences in form of SP/SR. Triangulation across groups enhances credibility of findings in qualitative research, and gives us some confidence that these four categories may hold good in other groups, while differences in form of presentation of SP/SR (on own vs. in pairs) may account for the relative differences in the two more specific CT skill categories. In retrospect, it would have been helpful either to have carried out the same systematic investigation (specific questions and self-observational data collection) with the other 10 therapists, or to have reinforced the data with data from a new SP/SR group of experienced therapists; however, this was beyond the scope of the present research.

Having gone some way towards mapping the impact of SP/SR on therapist skills, as well as therapist understandings and therapist self-concept (Bennett-Levy et al., 2001), future research should examine the impact of SP/SR, and other experiential training approaches (e.g. personal therapy) in larger samples, using quantitative measures. Existing measures (e.g. the Cognitive Therapy Scale) may need to be adapted for this purpose, since they do not adequately represent some dimensions of therapist performance impacted by SP/SR (e.g. therapist flexibility, therapist self-reflection, use of metaphors based on personal experience).

Future research should also delineate conditions under which SP/SR may be most valuable, and conditions under which it is contraindicated. Bennett-Levy et al. (2001) made some preliminary suggestions (e.g. longer courses, clear agreements, choice to participate), but these dimensions need to be more fully articulated to provide a framework for trainers wishing to use an SP/SR-based approach in training courses.

There is also a need to develop theoretical underpinnings for SP/SR. Bennett-Levy et al. (2001) invoked Epstein's (1994) distinction between rational and experiential information processing systems as a framework to explain why participants reported SP/SR led to a ''deeper sense of knowing'' of CT practices than more traditional learning techniques. They suggested that the impact of SP/SR might lie in its strong representation in *both* systems. The development of a more articulated theoretical framework should lead to greater understanding of the potential value of SP/SR, and other experiential approaches.

We conclude that SP/SR represents a promising training strategy, with self-reported changes in therapist skill that are consistent with therapist qualities that previous research has demonstrated are associated with good outcomes. There are also good theoretical grounds from adult learning theory to suggest the potential value of SP/SR.

As a training technique, our experience suggests that SP/SR may represent a useful middle path between personal therapy and no experiential work, which is acceptable to institutions, practitioners and students. The purpose and focus of SP/SR is clearly on training. Confidentiality can be maintained, and dual relationships avoided between trainer and participants. Participants need to be provided with adequate safeguards, in case they do experience distress (see Bennett-Levy et al., 2001), and alternative options where SP/SR is contraindicated (e.g. concurrent stressful life events). Under these conditions, SP/SR may provide a safe,

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

controlled alternative to personal therapy, which maximizes the benefits of personal experiential work and self-reflection for therapist development, while containing it within the context of training and academic courses.

Acknowledgements

The authors would like to thank Norma Morrison and Ann Hackmann for helpful comments on earlier drafts of the paper.

References

Albert, G. (1997). What are the characteristics of effective psychotherapists? The experts speak. *Journal of Practical Psychology and Behavioural Health, 3,* 36–44.

Baker, S. D., Daniels, T. G., & Greeley, A. T. (1990). Systematic training of graduate-level counselors: Narrative and meta-analytic reviews of three major programs. *The Counseling Psychologist, 18,* 355–421.

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology: A research guide*. Buckingham: Open University Press.

Basco, M. R. (2000). Cognitive-behavior therapy for bipolar I disorder. *Journal of Cognitive Psychotherapy, 14,* 287–304.

Beck, A. T., Freeman, A., & Associates (1990). *Cognitive therapy of personality disorders*. New York: Guilford.

Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (1993). *Cognitive therapy of substance abuse*. New York: Guilford.

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

Beck, R. L., & Munson, C. E. (1988). Family-of-origin experience in a psychotherapy training program. *Social Casework, 69,* 54–57.

Bennett-Levy, J. (2003a). Navel gazing or valuable training strategy? Self-practice of therapy techniques, self-reflection, and the development of therapist expertise. In J. Henry (Ed.), *First European positive psychology conference proceedings*. Leicester: Consciousness and Experiential Psychology Section/British Psychological Society.

Bennett-Levy, J. (2003b). Mechanisms of change in cognitive therapy: The case of automatic thought records and behavioural experiments. *Behavioural and Cognitive Psychotherapy*, in press.

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

Boud, D., Keogh, H. R., & Walker, D. (Eds.) (1985). *Reflection: Turning experience into learning*. London: Kogan Page.

Burns, D. D., & Auberbach, A. (1996). Therapeutic empathy in cognitive-behavioral therapy: Does it really make a difference? In P. M. Salkovskis (Ed.), *Frontiers of cognitive therapy* (pp. 135–164). New York: Guilford.

DeRubeis, R., & Feeley, M. (1990). Determinants of change in cognitive therapy of depression. *Cognitive Therapy and Research, 14,* 469–482.

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

Epstein, R. M. (1999). Mindful practice. *Journal of the American Medical Association, 282,* 833–839.

Feiner, S. E. (1998). Course design: An integration of didactic and experiential approaches to graduate training of group therapy. *International Journal of Group Psychotherapy, 48,* 439–460.

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

Fennell, M. J. V., & Teasdale, J. D. (1987). Cognitive therapy for depression: Individual differences and the process of change. *Cognitive Therapy and Research, 11,* 253–271.

Freud, S. (1937/1957). Analysis terminable and interminable. In J. Strachey (Ed.), *Complete psychological works of Sigmund Freud.* London: Hogarth Press.

Friedberg, R. D., & Fidaleo, R. A. (1992). Training inpatient staff in cognitive therapy. *Journal of Cognitive Psychotherapy, 6,* 105–112.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory.* New York: Aldine.

Gray, J. J. (1991). Clinical roundtable: Should trainees undergo psychotherapy? *The Behavior Therapist, 14,* 257.

Greenberg, L. S., & Goldman, R. L. (1988). Training in experiential therapy. *Journal of Consulting and Clinical Psychology, 56,* 696–702.

Greenberger, D., & Padesky, C. (1995). *Mind over mood.* New York: Guilford Press.

Hayes, N. (Ed.) (1997). *Doing qualitative analysis in psychology.* Hove: Psychology Press.

Hollon, S. D., Shelton, R. C., & Davis, D. D. (1993). Cognitive therapy for depression: Conceptual issues and clinical efficacy. *Journal of Consulting and Clinical Psychology, 61,* 270–275.

Ilardi, S. S., & Craighead, W. E. (1994). The role of nonspecific factors in cognitive-behavior therapy for depression. *Clinical Psychology: Science and Practice, 1,* 138–156.

Keijsers, G. P. J., Schaap, C. P. D. R., & Hoggduin, C. A. L. (2000). The impact of interpersonal patient and therapist behavior on outcome in cognitive-behavior therapy. *Behavior Modification, 24,* 264–297.

Kemmis, S., & McTaggart, R. (2000). Participatory action research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Kingdon, D., Tyrer, P., Seivewright, N., Ferguson, B., & Murphy, S. (1996). The Nottingham study of neurotic disorder: Influence of cognitive therapists on outcome. *British Journal of Psychiatry, 169,* 93–97.

Kolb, D. (1984). *Experiential learning: Experience as the source of learning and development.* Englewood Cliffs, NJ: Prentice Hall.

Laireiter, A-R. (1998). Self-directed experience and personal therapy: The situation in German-speaking countries and the ''state of the art'' of empirical research. In E. Sanavio (Ed.), *Behavior and cognitive therapy today: Essays in honor of Hans J. Eysenck* (pp. 163–179). Oxford: Elsevier.

Linehan, M. M. (1993). *Cognitive-behavioural treatment of borderline personality disorder.* New York: Guilford.

Linehan, M. M., & McGhee, D. E. (1994). A cognitive-behavioural model of supervision with individual and group components. In S. E. Greben (Ed.), *Clinical perspectives on psychotherapy supervision* (pp. 165–188). Washington, DC: American Psychiatric Press.

Macran, S., & Shapiro, D. (1998). The role of personal therapy for therapists: A review. *British Journal of Medical Psychology, 71,* 13–25.

McDaniel, S. H., & Landau-Stanton, J. (1991). Family-of-origin work and family therapy skills training: Both-and. *Family Process, 30,* 459–471.

Miles, M., & Huberman, A. M. (1994). *Qualitative data analysis: A sourcebook of new methods.* Thousands Oaks, CA: Sage.

Milne, D., Claydon, T., Blackburn, I. M., & James, I. (2001). Rationale for a new measure of competence in therapy. *Behavioural and Cognitive Psychotherapy, 29,* 21–33.

Norcross, J., Dryden, W., & DeMichele, J. T. (1992). British clinical psychologists and personal therapy: III. What's good for the goose? *Clinical Psychology Forum* (*June*), 29–33.

Orlinsky, D. E., Botermans, J-F., Rønnestad, M. H., & The SPR Collaborative Network (2001). Towards an empirically grounded model of psychotherapy training: Four thousand therapists rate influences on their development. *Australian Psychologist, 36,* 139–148.

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

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press

Padesky, C. A., & Greenberger, D. (1995). *Clinician's guide to Mind Over Mood*. New York: Guilford.

Pidgeon, N. (1996). Grounded theory: Theoretical background. In J. T. E. Richardson (Ed.), *Handbook of qualitative research methods* (pp. 75–85). Leicester: British Psychological Society.

Rennie, D. L., Brewster, L. J., & Toukmanian, S. G. (1985). The counsellor trainee as client: Client process as predictor of counselling skill acquisition. *Canadian Journal of Behavior Science, 17,* 16–28.

Rice, L., & Greenberg, L. S. (Eds.) (1984). *Patterns of change: Intensive analysis of psychotherapeutic process*. New York: Guilford.

Richardson, J. T. E. (Ed.) (1996). *Handbook of qualitative research methods*. Leicester: British Psychological Society.

Robertson, D. L. (1996). Facilitating transformative learning: Attending to the dynamics of the educational helping relationship. *Adult Education Quarterly, 47,* 41–53.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford.

Safran, J. D., & Muran, J. C. (2001). A relational approach to training and supervision in cognitive therapy. *Journal of Cognitive Psychotherapy, 15,* 3–15.

Safran, J. D., & Segal, Z. V. (1990). *Interpersonal processes in cognitive therapy*. New York: Basic Books.

Schön, D. A. (1983). *The reflective practitioner*. New York: Basic Books.

Schön, D. A. (1987). *Educating the reflective practitioner*. San Francisco: Jossey-Bass.

Skovholt, T. M. (2001). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals*. Boston: Allyn and Bacon.

Skovholt, T. M., & Rønnestad, M. H. (1992). *The evolving professional self: Stages and themes in therapist and counselor development*. Chichester: Wiley.

Skovholt, T. M., Rønnestad, M. H., & Jennings, L. (1997). The search for expertise in counseling, psychotherapy, and professional psychology. *Educational Psychology Review, 9,* 361–369.

Smith, J. A., Harre, R., & Van Langenhove, L. (Eds.) (1995). *Rethinking methods in psychology*. London: Sage.

Spencer, L. (1989). *Winning through participation: Meeting the challenge of corporate change with the technology of participation*. Dubuque, Iowa: Kendall Hunt.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273–285). Thousand Oaks, CA: Sage.

Strupp, H. H., Butler, S. F., & Rosser, C. L. (1988). Training in psychodynamic therapy. *Journal of Consulting and Clinical Psychology, 56,* 689–695.

Whisman, M. A. (1993). Mediators and moderators of change in cognitive therapy of depression. *Psychological Bulletin, 114,* 248–265.

Williams, F., Coyle, A., & Lyons, E. (1999). How counselling psychologists view their personal therapy. *British Journal of Medical Psychology, 72,* 545–555.

Wills, F., & Sanders, D. (1997). *Cognitive therapy: Transforming the image*. London: Sage.

Young, J., & Beck, A. T. (1980). *The Cognitive Therapy Scale* (Unpublished manuscript). Philadelphia: Center for Cognitive Therapy.

Zuber-Skerritt, O. (Ed.) (1996). *New directions in action research*. London: Falmer.

https://doi.org/10.1017/S1352465803002029 Published online by Cambridge University Press