

# Reflective Practice in Cognitive Behavioural Therapy: The Engine of Lifelong Learning

James Bennett-Levy, Richard Thwaites, Anna Chaddock & Melanie Davis

Chapter to appear in R. Dallos & J. Stedmon (ed) *Reflection in Psychotherapy and Counselling*

## Introduction

Reflection plays a significant, indeed central, role in cognitive behaviour therapy (CBT), in common with other therapies. The importance of reflection has been implicit in CBT writing from the earliest stages. For instance, one of the cornerstones of CBT, the use of Socratic questioning to identify and testing thoughts and underlying assumptions, is quintessentially a reflective practice both for clients (Beck, Rush, Shaw & Emery, 1979) and therapists (Padesky, 1996).

Until recently, what has been absent from the CBT literature is the language of reflection. This has led to a common misperception that CBT therapists don't reflect. Nothing could be further from the truth! As we shall demonstrate in this chapter, CBT therapists use a variety of methods (e.g. supervision, self-supervision, self-practice/self-reflection, reflective journals) and data from various sources (client presentation, feedback from clients and supervisors, measures of client progress, review of therapy tapes, CBT literature, self-reflections etc) to reflect on their practice. For instance, although not explicitly using the term "reflection", Padesky (1996, p.273-4) wrote: "The art and skill of therapy are best developed in a therapist who consistently analyses and learns from both positive and negative client feedback and outcome."

CBT therapists not only reflect on their clinical practice, but also on their personal selves (the "person of the therapist"), particularly when this impacts on their practice. When interpersonal issues arise in therapy, self-reflection is a recommended practice – for instance, see Beck, Freeman et al.'s (1990) *Cognitive Therapy of Personality Disorders* and Safran and Segal's (1990) *Interpersonal Processes in Cognitive Therapy*. As Beck, Freeman et al. (1990, p.252) noted: "To manage the limits of the therapeutic relationship effectively, and to use their personal reactions in the process of treatment, cognitive therapists must first be sensitive observers of their own thoughts, feelings, and beliefs." In CBT supervision, therapist self-reflection is often prompted by a particular therapeutic problem, frequently interpersonal in nature; for instance, Haarhof and Kalantzis (2007) provide CBT supervision case examples where identifying therapist schemas was central to addressing therapy-interfering beliefs. CBT supervisors observe explicit boundaries. As Padesky (1996, p.285) has written: "In supervision, therapist

emotional reactions, schemas, and developmental history are used to inform understanding of the dilemmas faced by a therapist conducting therapy; they are not explored for their own sake.”

More recently, as we shall illustrate in this chapter, self-practice of cognitive therapy techniques and self-reflection (known as SP/SR) has been formalized in a training context as a self-experiential/reflective tool to enhance clinical practice (Bennett-Levy, Lee, Travers, Pohlman & Hamernik, 2003; Bennett-Levy, Turner, Beaty, Smith, Paterson & Farmer, 2001; Laireiter & Willutzki, 2003). In SP/SR, trainees practice CBT techniques on themselves, either on their own or in a limited ‘co-therapy’ relationship, and then reflect on their experience through individual written reflections and shared group reflections (written or in person). Typically these reflections encompass implications of the self-practice for self, for clinical practice and for cognitive theory.

One distinction between CBT and some other schools of therapy is that personal therapy is not a formal requirement of CBT training in some countries (e.g. UK, USA, Australia), though it is in others (e.g. Sweden, Germany). CBT therapists make a distinction between personal experiential work as a method of personal development and as a training tool to enhance CBT practice (Bennett-Levy, 2005). There is increasing evidence to suggest that SP/SR impacts in both ways (Bennett-Levy et al., 2001; Davis, Thwaites, Freeston & Bennett-Levy, 2008). Personal therapy is usually a longer and deeper process than SP/SR, but is perhaps less targeted as a training tool - as therapy clients, we usually focus on our “personal self” and do not necessarily reflect on the clinical implications. At the present time, there is no evidence to indicate the impact of personal therapy on CBT practice.

From about 2000, the term “reflection” started to make an appearance in the CBT literature when researchers focused more intently on therapist skill development (Bennett-Levy et al., 2001; Milne, Claydon, Blackburn, James & Sheikh, 2001; Safran & Muran, 2000), and started to link the CBT literature with the adult learning literature, since extant models of learning seemed inadequate to account for the higher order metacognitive demands on the therapist (Bennett-Levy, 2003). The grandparents of modern day reflection, Dewey (1938) and Lewin (1948), and the 1980s writings of Schön (1983), Kolb (1984), Boud, Keogh and Walker (1985), and action researchers Kemmis and McTaggart (1988) have all been significant influences on recent developments linking the adult learning literature with CBT. However, as CBT therapists, our epistemological bias towards empiricism has differed from some of those authors. For CBT therapists, the very act of evaluative research, and use of measurement in individual therapy, is an intrinsically reflective practice. Empirical evidence and clinical experience have led to progressive refinement of treatment protocols across many psychological disorders. As Mansell (2008, p.648) has written: “Theory and scientific evaluation are at the heart of developments in CBT ... there is a reciprocal relationship between science and practice.” The same principles apply to CBT writing on reflection. Once we started to use the language of reflection within

CBT, our focus naturally turned to conceptualizing reflection, and measuring its value as a tool for learning CBT therapy skills.

The aims of this chapter are, first, to clarify what is meant by “reflection” in CBT. We have become increasingly dissatisfied with the fuzziness of the term, and the varying ways it has been used, including by ourselves. At the very least, getting clear about distinctions in usage and developing a working definition should help. Second, we review recent evidence supporting the value of reflection as a significant component in CBT training. Third, we provide examples of reflective practice in CBT from training and supervision of CBT therapists, and from a clinical example. And fourth, we conclude that while the process of reflection is clearly central to the practice of CBT, the definition and varied usages of the term “reflection” require more precise specification. Whether the term “reflection” will survive this more precise specification or whether it will be replaced by more specific descriptors of process, we are uncertain.

### **Reflection – Clarifying the Term**

In their enthusiasm to embrace the notion of reflection, CBT theorists - and writers from other therapeutic traditions - have used the terms “reflective” and “reflection” in a range of contexts without always being clear about the distinctions. We can identify at least four ways in which these terms have been used in the CBT literature:

1. **Reflective practice** has been used to refer to the activity of reflecting on clinical experience, including personal reactions, attitudes and beliefs. Reflective practice may be a self-supervision activity, and/or a practice facilitated within clinical supervision. Reflective journals, blogging, SP/SR (see below) and activities such as reviewing videotapes are all forms of reflective practice.
2. **Reflective skill** refers to the ability of the practitioner to reflect on themselves or their practice. Bennett-Levy and Thwaites (2007) have postulated that therapists need two kinds of reflective skill:
  - (i) General reflective skills, which refer to the general capacity to reconstruct and explore events (e.g. a therapeutic interaction), and to conceptualize and synthesize the resulting information (e.g. create a formulation);
  - (ii) Self-reflective skills, which require general reflective skills, but also makes more specific demands on the self (e.g. to identify and explore one’s own feelings and thoughts). Bennett-Levy and Thwaites (2007) have suggested that some therapists may be quite adept at one form of reflection e.g. general reflection, but avoidant of another e.g. self-reflection.
3. The **Reflective system** forms one of the key elements of the Declarative-Procedural-Reflective (DPR) information processing model of therapist skill development (Bennett-Levy, 2006, Bennett-Levy & Thwaites 2007), which has provided a theoretical base for our work. In brief, we have suggested that

therapist development depends on the positive interaction between three information processing systems: the declarative memory system, which is the storehouse of theory, facts and information about the therapy (in this case CBT, but could be any therapy approach); the procedural system, which stores and generates the practical skills of therapy, the *skills-in-action*; and the reflective system. Following Schön (1983), and Skovholt and Rønnestad (1992), we have highlighted the reflective system as the “engine” which drives lifelong learning as a therapist, particularly once basic therapy skills have been learned. It is by using their “reflective systems” that therapists identify the need to refine their declarative knowledge and procedural skills (see Fig.1); and it is by reflecting on clinical experience that they learn to discriminate which skill to apply to which client under which set of circumstances at which point in time in therapy.

*Figure 1 about here*

For the purposes of this chapter, we present a new perspective on the reflective system, which places it at the centre of therapist skill development (see Figure 2). In the past, the pictorial representation of the reflective system in the DPR model has arguably been too peripheral (see Bennett-Levy, 2006).

*Figure 2 about here*

What does the reflective system reflect on? In a nutshell, we usually focus the reflective system either on *practice* (e.g. client presentation, formulation, therapeutic relationship, treatment plan, measures of therapeutic progress) or on the *self* (self-as-therapist, self-as-supervisor, personal self), or on both in combination. Figure 2 focuses on some of the “self” aspects (self-as-therapist, personal self). Our research has suggested that reflection may be particularly important for the development and refinement of therapist interpersonal skills (Bennett-Levy et al., 2003, Chaddock, Thwaites, Freeston & Bennett-Levy, 2006; Davis et al., 2008). Hence we have highlighted the four components of the interpersonal system (Thwaites & Bennett-Levy, 2007) in Figure 2 (in the white rectangles).

**4. Reflection as process.** Both the adult learning literature and the CBT literature have been confusing in their use of the term “reflect”. Following Kolb (1984), Milne et al (2001) have used the term “reflective observation” to describe the observation phase of the experiential learning circle and “abstract conceptualisation” to describe the conceptualisation phase; following Kemmis and McTaggart (1988), Bennett-Levy, Butler, Fennell, Hackmann, Mueller and Westbrook (2004) have used the term “observe” to describe the observation phase and “reflect” to describe the conceptualisation phase.

*Figure 3 about here*

The way we have resolved this confusion is depicted in Figure 3, which is an adaptation of the DPR reflective system (Bennett-Levy & Thwaites, 2007). We have used the terms [focused attention], [reconstruct + observe] and [conceptualize + synthesize] to describe three phases of the reflective process, and reserved the term “reflective” or “reflect” only to describe the whole process. In practice,

the reflective system needs to be linked to action, as illustrated in the supervision and clinical examples later in the chapter.

To summarize, our working definition of reflection-as-process is:

*Reflection is the process of actively focusing one's attention on a particular content; observing and clarifying this focus; and, through using other knowledge and cognitive processes (such as self-questioning, logical analysis and problem solving to derive a conceptualization. Self-reflection is a specific form of reflection in which the content for reflection is self-referenced to one's thoughts, feelings, behaviours or personal history.*

### **Methods of Reflection within CBT**

A number of methods have been used for reflection within CBT. Supervision (Padesky, 1996) and self-supervision (Bennett-Levy & Thwaites, 2007) are perhaps the primary methods. Other methods include self-practice/self-reflection, which has come to be known as SP/SR (Bennett-Levy et al., 2001); reflection in groups, either via email (Chaddock et al., 2006) or blogging (Farrand, Perry, & Linsley, 2008) or in person (Bennett-Levy et al., 2003); reflective journals (Sutton, Townend & Wright, 2007); personal therapy (Beck & Butler, 2005); self-assessment of CBT skills (Bennett-Levy & Beedie, 2007); analysing and evaluating empirical research; and reflective writing (Bolton, 2001) including essays and academic writing (for example, this chapter which has required considerable reflection on reflection). In the sections that follow, we give examples of reflection in CBT drawn from supervision, SP/SR training and clinical practice.

### **Reflection in Training**

As it has only been in recent years that reflection has been given a language within CBT, it is perhaps unsurprising that, to date, there has been a relative paucity of empirical studies investigating reflection and reflective processes within CBT. However, with increasing specificity in the modelling of reflective processes, an encouraging evidence-base for incorporating reflection in CBT training has been emerging, particularly in relation to the SP/SR (self-practice/self-reflection) approach. As SP/SR offers a personal experiential approach to training, it has the potential to offer avenues to skill enhancement that may not be possible via traditional means. Therefore we will concentrate mainly on SP/SR as an example of "how to" reflect during training, partly because it has by far the strongest evidence base, partly because we have been involved in developing and researching this approach, but also because there are a range of different reflective methods within the reflective component of this approach. SP/SR would therefore seem to be relatively representative of reflective practice within the cognitive and behavioural

therapies. To aid our discussion, we outline how reflection is facilitated through SP/SR and end with a training case study to illustrate the benefits of this approach.

### **Facilitating Self-Practice/Self-Reflection**

SP/SR is a focused training tool designed to give CBT therapists a personal therapy-like experience through the practicing of CBT techniques on the self, along with the experience of reflecting on, and integrating what has been learnt during the self-practice. To date it has been delivered in two conditions: within pairs of “co-therapists”, or on an individual basis using a manualized workbook. The self-practice element within the workbook condition consists of a set of structured tasks and activities to be completed week by week over a set period of time (usually about 10-12 weeks). These therapeutic tasks follow more or less what you might expect to find in a course of CBT of equivalent length, such as activity schedules, thought diaries, behavioural experiments and positive data logs. In the “co-therapists” condition, SP/SR participants typically have six sessions in both therapist and client roles. They use CBT interventions as they would in “normal therapy”; and then reflect on the experience, both verbally immediately after the session and later in written form.

The workbook has been the most commonly used format, and the one we will explore further within this part of the chapter. Although trainees work through the SP workbook exercises on an individual basis, SP/SR has so far only been delivered within a group setting. The participants might be a group of trainee CBT therapists, or experienced CBT therapists interested in further skill development, and there is a growing evidence base suggesting that SP/SR can be of benefit to both. Our experience suggests that it is best to have a facilitator having regular contact with those completing the programme, who can be consulted should any difficulties arise.

### **The Reflective Process in SP/SR**

At the beginning of the chapter, the distinction was made between the reflective system, reflective process, and reflective practice. Using the SP/SR workbook, participants engage in the reflective practice in various ways. First, at the start of the workbook, they target some specific aspects of practice or therapy skill which they wish to monitor over the course of the programme. Next they engage with CBT techniques themselves. As participants work through the SP exercises, they are asked to respond to reflective questions, to look in depth at the implications of their experience for themselves, their clients, and cognitive therapy in general. The focus of the reflective questions, and their progression, typically follow the structure below.

1. Observe the experience (e.g. how did I feel, what did I notice?)

2. Clarify the experience (e.g. was it helpful, what didn't change?)
3. Implications of the experience for clinical practice (e.g. for one-to-one therapy, for supervision and consultation etc)
4. Implications of the experience for how I see myself as 'person of the therapist' and/or 'self-as-therapist'.
5. Implications of this experience for my understanding of cognitive therapy and theory.

In relation to the reflective process, the first and second questions are about self-observation and reconstruction of the experience, with the final three questions operating more at the level of conceptualization of the experience and synthesis of new ideas and new information. These structured questions can be particularly useful for novice therapists, or novice reflectors, and can help participants begin to learn and internalize a self-questioning style in their everyday practice.

At the end of each week, each participant writes a summary of their reflections for that week, which is circulated to the rest of the group via the group facilitator, or online as a "blog". Due to the nature of the self-practice exercises, participants' reflections may concern sensitive information such as personal beliefs and feelings, hence contributions are made anonymously. This sharing of reflections seems to be important in the reflective process. It normalizes the individual participant's experiences and helps facilitate increasing depth of reflection by stimulating new trains of thought. These written reflections are more analogous to the completion of a reflective journal, which is a method commonly practiced across therapies, but is also an applied method within CBT (e.g. Sutton et. al. 2007). At the end of the programme there is a longer reflective exercise where participants are asked to complete a reflective summary of their overall SP/SR experience, and perhaps a de-briefing session or reflective interview with the facilitator.

To summarize, in SP/SR the SR element is designed to facilitate the reflective process. The structure of the exercises aims to help the therapist to synthesize their learning during the SP/SR programme, and further develop their reflective skills.

### **The SP/SR Research Programme**

The research programme began with two initial qualitative studies conducted in Australia. The first made use of a manualized, workbook with trainee clinical psychologists who were mostly new to CBT (Bennett-Levy et al., 2001). The second study featured more experienced CBT therapists, some of whom used the workbook and some who did SP/SR "co-therapy" (Bennett-Levy et al., 2003). The therapists reported that engaging in personal experiential work through SP/SR deepened their "sense of knowing" CBT (Bennett-Levy et. al., 2001, p. 203). More specifically, in line with the theoretical understanding of the reflective system in the DPR model of therapist skill development (Bennett-Levy, 2006; Bennett-Levy &

Thwaites, 2007), the findings of these studies, based on therapist self-reports, suggested that SP/SR enhances CBT knowledge and understanding (declarative system), CBT skills (procedural system) and metacognitive abilities such as reflective capacity, therapist flexibility and self-perception of competence (Bennett-Levy & Beedie, 2007). In particular, it was suggested that SP/SR may have a specific primary impact on interpersonal aspects of therapist performance such as empathic attunement and interpersonal communication skills (Bennett-Levy et al., 2003).

Over the past five years, SP/SR has been incorporated and evaluated in case series studies carried out on diploma-level CBT training courses linked with the Universities of Cumbria and Newcastle. As we have progressed, study design and measures have become more refined, with quantitative measurement incorporated alongside strengthened, quasi-experimental designs. Preliminary results from these more recent studies suggest that previous qualitative results do translate into quantitatively measurable differences in skill as assessed by participants' self-ratings of empathy and competence in CBT for both trainee (Chaddock et al, 2006; Thwaites, Chaddock & Bennett-Levy, 2006) and experienced CBT therapists (Davis et al, 2008). In addition, it appears that benefits of SP/SR can also be gained via online delivery in "blogging" form (Farrand et. al., 2008). The findings indicate promising initial evidence for SP/SR programs in enhancing interpersonal skills and CBT-specific skills.

Whilst these studies, originating in Australia and the UK have been the first of their kind, alongside associated work by Haarhoff (Haarhoff, 2006; Haarhoff & Kazantzis 2007) in New Zealand exploring the impact of CBT therapists' self-schemas on their clinical practice, there has been a longer history of personal experiential programmes within CBT in continental Europe. In their overview of personal experiential programmes, Laireiter and Willutzki (2003) noted the substantial benefits of including self-practice/self-reflection approaches in CBT training. Although the authors acknowledged that empirical evidence for such programmes was not extensive at the time of the review, the available evidence supported the value of such programmes in fostering the development of important personal and interpersonal competencies.

### **SP/SR Case Example**

To illustrate how SP/SR facilitates the reflective process and how it might impact on learning about self and about therapy, we present a single-case observational study of a CBT trainee with data taken from one of our larger case-series. The case study gives a practical example of how some of these practices can be applied in personal/professional development work.

The participant, who we will refer to as "Tim", was a trainee CBT therapist in his mid-thirties, with over 10 years nursing experience within mental health. He was undertaking SP/SR as an adjunct to his CBT degree, following the foundation module. As described previously, Tim rated his clinical competence on

a number of different items before, during and after completing the SP/SR workbook for novice therapists. One of the items Tim selected to self-monitor was “Guided Discovery”. Specifically, guided discovery refers to “using effective questioning to help patients develop new perspectives regarding their current situation which provides opportunities for re-evaluation and new learning to occur” (James, Blackburn, Milne & Reichelt, 2001) - an item particularly pertinent to our current discussion of reflection . Figure 4 illustrates how Tim rated his competence in undertaking guided discovery with his clients during the baseline, SP/SR and consolidation phases of the study (where 0=not at all competent, 100=highly competent). Looking at the pattern of ratings over time, it is clear that Tim showed a consistent pattern of steady gain over the SP/SR period, with less change in ratings over the consolidation phase.

*Insert Figure 4 here*

In other words, this data would appear to show that Tim’s self-perceived competence in using guided discovery with patients increased over the time he was completing SP/SR, but did not increase greatly when he was just receiving standard training.

Using an example from Tim’s reflections following completion of the seventh week of the programme (self-application of a cognitive conceptualization), we can further explore the process of learning in SP/SR.

(1) *“I found this quite difficult to apply to myself and yet when I’m working with clients it’s as if their assumptions and core beliefs are jumping out at me... I decided to wait until an incident occurred and use Socratic dialogue on myself to try and complete the exercise.”*

The experience of trying to apply the conceptualization to himself seems to have stimulated Tim’s reflective system [*focused attention*], providing an opportunity to *reconstruct and observe* his own experience at a personal and a clinical practice level. Tim goes on to think about, and further identify what is different between his own experience of applying the conceptualization and his experience with clients - the *conceptualize and synthesize* phase of the reflective process.

(2) *“I think the main difference is that working with underlying beliefs is that they are so entrenched that I don’t really recognize when they do come into play. It’s just automatic. I think and believe what I do because I do.”*

In the final part of the reflection, Tim’s engagement in Socratic dialogue with himself, with the aid of the reflective questions within SP/SR, resulted in a “deeper sense of knowing” both of CBT theory and of himself.

(3) *“Most of my beliefs are around acceptance from others and whether I am liked... what I realized was just how many compensatory behaviours I use routinely in most situations. Being aware of when these are used for positive reasons and when for negative has been the most useful thing*

*that I've learned in terms of my work with clients and helping them to recognize when these come into play and whether it is helpful or detrimental to them is probably the most useful in terms of CBT work."*

Reflection would seem to be the key to Tim's learning from self-practice. In his reflections the participant makes reference to realizations and connections made through reflection that perhaps, on the basis of self-practice alone, would not have been made. This is also evident in the following examples, which are transcribed from an interview conducted at the end of the SP/SR program:

(4) *"I think where SPSR has been useful is in setting the framework and the boundaries ... a context to think about it. It hasn't just been me going off on a tangent. It set parameters, but with scope to adapt to my needs."*

(5) *"[SR] cemented things and helped me to make connections with things..."*

(6) *"... particularly thinking about what I'm doing and why I'm doing it, rather than just thinking about using techniques and strategies... it's thinking about how they fit with the clients and what's going on in the session."*

We would argue therefore, that it was through reflection that his experience of self-practice and his implicit learning became explicit and realized. These reflections are certainly consistent with the conceptualization of the reflecting system within the DPR model (Bennett-Levy, 2006), which we described at the beginning of the chapter. Focused attention through reflective questions and tasks (quotation 4) leads to observation and re-construction of the material which can be subject to further conceptualization and synthesis such as relating practical experience to theory (5 & 6).

Further, we would suggest that quotation 4 highlights another important point about the nature of reflection, particularly regarding novice therapists and the development of reflective skills. In the quotation, Tim reflects that SP/SR helped to provide a structure for his reflections, preventing the process from being aimless or taking on a ruminative quality, which could end up reinforcing unhelpful beliefs.

The evidence presented here suggests that the use of reflective methods such as SP/SR in CBT training can enhance both technical and interpersonal skills. This is consistent with the developing theoretical understanding of reflective processes described earlier. The way in which we approach reflective practice in training is clearly important, and should provide opportunities to engage in the processes identified in Fig 3. Reflection is an essential part of the therapeutic process, not only for the client but also the therapist. We would go so far as to say that a competent CBT therapist, by definition, must also be a reflective CBT therapist. In training however, whether it be a half-day workshop, a week's foundation course, or fully accredited training, we must also be effective learners. Given this, it logically follows that reflection might be considered of particular importance during a period of training as this

entails “general learning” and “learning about therapy”. Just as the reflective process is central to a client’s progression through therapy, a reflective process is also central to a therapist’s learning to practice therapy.

## Reflection in supervision

Earlier in the chapter we identified the process of reflection as one of the necessary stages of learning (Bennett-Levy, 2006; Kolb, 1984) and therefore as an essential element of effective supervision<sup>1</sup>. This has been recognized by most CBT models of supervision (Armstrong & Freeston, 2006; Milne, James, Keegan & Dudley, 2002) and by a recent survey of UK CBT course leaders (Townend, 2008) which suggested that reflection was one of the processes “at the heart of decision making within cognitive behavioural psychotherapy supervision, and thus linked to the learning processes of supervision” (p.334). Supervision without reflection is highly unlikely to help the supervisee develop new therapeutic skills that can be applied flexibly, effectively and sensitively. Psychotherapy without reflective skills is likely to be less sensitive, more likely to get “stuck” or result in an unresolved interpersonal rupture.

For the purposes of this discussion we are choosing to emphasize the role of the supervisor in *facilitating reflection by the supervisee*. However the supervisor also needs to utilize their own reflective skills to identify their thoughts and feelings about the supervisee and to avoid getting hooked into unhelpful interpersonal processes e.g. collusion with the supervisee (Milne, submitted for publication). In this section we will provide an example of a supervision process model which can be used to maximize functional reflection and train reflective skills in the supervisee. First we will briefly examine some of the specific responsibilities of the supervisor and also the supervisee(s) in developing these skills.

### *Supervisor*

The role of the supervisor in engendering reflection in the supervisee is two-fold: to help the supervisee to reflect on, and conceptualize, their own experiences and actions *within the supervision session* and to develop the skills to use reflection *outside the supervision session* (e.g. within clinical sessions, self-supervision). To achieve both requires an underlying atmosphere of acceptance and warmth (despite inherent difficulties when supervision contains an evaluative component such as during training), the modelling of an openness to new ways of thinking and feeling, appropriate pacing, and the effective use of relevant microskills such as scaffolding (James, Milne & Morse, 2008).

---

<sup>1</sup> We are using the recent definition of supervision as ‘the formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleague/s’ (Milne, 2007) though we are emphasising the education and training aspects of this definition here.

Supervisees often feel vulnerable and fear negative evaluation by their supervisor (Bennett-Levy & Beedie, 2007). The process of therapy involves a range of skills, both technical and interpersonal, many of which involve the “person of the therapist” in addition to the “self-as-therapist” (Thwaites & Bennett-Levy, 2007). Supervisees can often feel that being negatively evaluated as a therapist is in some way akin to being negatively evaluated as a person and there is considerable evidence that some supervisees may need explicit normalization of their own emotional reactions and an accepting and non-judgemental environment to overcome any anxieties about discussing their emotional reactions to clients or specific issues (Bennett-Levy & Thwaites, 2007).

Recent research has begun to focus on the role of supervisor microskills in supervision such as scaffolding, a concept based on Vygotsky’s idea of the “zone of proximal development” (Vygotsky, 1978 cited in James, Allen & Collerton, 2004). Scaffolding involves the use of verbal and non-verbal strategies that “provide temporary support to the supervisee in order to help him or her to learn something new based on the foundations of what was already known” (James, Milne & Morse, 2008, p.30). The use of both platforms and questions are essential to the effective process of all types of reflection, and therefore learning, within supervision. An example of these might be ‘*You’ve been doing some reading around cognitive models of social anxiety and we last week talked about some of the processes that keep people believing the same thoughts despite available evidence [platform], how does this help us understand why Kim continues to believe that she is laughed at by everyone in the supermarket? [question]*’

### *Supervisee*

Although the supervisory relationship is often seen as primarily the responsibility of the supervisor as the expert and senior professional, the supervision process cannot effectively take place without the appropriate inputs by the supervisee. At the start of the supervision process, some CBT supervisors encourage supervisees to engage in self-reflection to identify their beliefs about themselves. For example, a supervisee early in their career may want to reflect on how they interact with others, why they have chosen the role of psychotherapist and why they have chosen this supervisor (if relevant). There are a variety of questionnaires the supervisees can complete which may facilitate this process such as the Dysfunctional Attitude Scale (Weissman & Beck, 1978) or the Young Schema Questionnaire (Young & Brown, 2001). They may want to reflect on the role of supervisor and supervisee, and on themselves as a CBT therapist. For example, the Therapists’ Schema Questionnaire (Leahy, 2001) can help supervisees think about their own beliefs about themselves as a therapist. Research suggests that certain therapist schema are more common in CBT trainees, including “demanding standards,” “excessive self-sacrifice,” and “special superior person” (Haarhoff, 2006), all of which are likely to impact on both the therapeutic process and also the supervisory process. For example, if a supervisee has

beliefs about having to “cure all their patients”, the inevitable reality of some patients not benefiting from the therapy could lead to her avoiding taking tapes to supervision, censoring what is reported, or even disengaging.

### *Supervision models*

There have been a number of models proposed that provide a supervision process framework for enhancing reflective skills and processes. Unfortunately space does not permit a more exhaustive discussion of these. However, of particular note though are the relational approach of Safran and colleagues (Safran & Segal, 1996), the Newcastle Cake Stand Model (Armstrong & Freeston, 2006), the evidence-based supervision model (Milne, in press) and the six stage model (Bennett-Levy & Thwaites, 2007). We will end this section by illustrating how the six stage model can facilitate the reflective processes of the supervisee within the supervision session. The example demonstrates how the six stage process (see Fig 5.) can be used to engage the reflective system, formulate the problem, establish a way forward and put into practice a new way of behaving (procedural skills) within therapy.

*Insert Figure 5 here*

#### *Stage 1: Focused attention on the problem*

The supervisee (David, a counsellor retraining in CBT) described a vague problem with a patient (Brenda) with panic disorder. Brenda was not improving as expected and further discussion identified that David already had his suspicions about what may have been happening. They shared a clear formulation: he knew that he should be encouraging the patient to engage in behavioural experiments to test out her catastrophic beliefs but couldn't bring himself to do it because of the increased distress it may cause her. Using the key supervisor microskill of scaffolding (James, Milne & Morse, in press), questioning by the supervisor (Jenny) established that David had a very good understanding of the panic model (declarative knowledge) and was able to apply it to Brenda. The problem was that every time they had put a hyperventilation experiment on the agenda, he would feel anxious, subsequently overrun with other items and it would be postponed until the following session. This was despite the client being keen to try the hyperventilation experiment, having already sought clearance from her own GP that this would not be dangerous!

#### *Stage 2: Re-construct and observe the experience*

It was agreed that a useful way of getting more detail about the situation (including David's emotional reactions and underlying thoughts) would be to use imagery to relive the most recent session where this had occurred (another possible option would have been to role play the session with the supervisor playing the role of Brenda following initial directions from David). David was encouraged to sit

comfortably, close his eyes, allow his breathing to slow down and visualize the moment in the last session when he was coming to the hyperventilation experiment as planned on the agenda. In order to access as much relevant detail as possible, David was guided to remember as much sensory information (e.g. "Can you describe the room?", "What was Brenda wearing?") and fill in the mental picture. David described out loud what was happening during the therapy including the actual words that the client used to describe her anxiety.

### *Stage 3: Clarifying the Experience*

David was guided to notice what was happening within his body as thoughts of the hyperventilation experiment came into his mind. He reported feeling a churning in his stomach and a feeling of physical agitation; this mirrored his reported feelings in the therapy session at this point. He reported feeling scared and anxious and the supervisor was able to help him to identify initial thoughts of "she will be distressed" and an image of Brenda having a panic attack and crying which further increased his physical sensations of anxiety. Guided questioning revealed further beliefs that "it would be awful if my client had a panic attack" and that it would be even worse if he were responsible. Finally he also reported that he would feel like a "bad person" if he caused more distress to his client.

### *Stage 4: Conceptualize and synthesize new information*

Supervisor and supervisee were able to construct a very simple formulation of David's thoughts and feelings, including some of his underlying rules and assumptions about distress and his role in ameliorating it. At this point the supervisor and David addressed his shame and embarrassment at the gap between his intellectual understanding of what needed to be done and his difficulty in doing this. The supervisor normalized and validated David's experience by providing anonymous examples of other supervisees who had struggled with similar issues. She also briefly referred to her own initial anxieties about creating distress in clients and how this is normal given some of the beliefs we may hold (therapist beliefs) and how these can change given repeated experiences of clients learning and changing their lives following distressing behavioural experiments. David laughed and commented that the client was having panic attacks every day and the only difference with this one would be that he was present for it, and felt responsible for it!

### *Stage 5: Practice procedural skills*

Within the supervision session, David role-played introducing and conducting a hyperventilation experiment, with the supervisor playing the part of Brenda. During this David noted his own automatic thoughts and anxieties though these did not significantly distract him from effectively implementing the hyperventilation experiment with a high degree of empathy and sensitivity.

### *Stage 6: Try out new strategy*

In David's next session with Brenda he successfully guided her through a hyperventilation experiment in which she had the first experience of the physical signs of anxiety and thoughts that she was going to have a heart attack and die, without her (or David!) carrying out a variety of safety behaviours. Following discharge, she identified this as the key moment in her recovery from three years of regular panic attacks and a life "not worth living."

### *Beyond Stage 6*

David generalized from this experience and began to see behavioural experiments as a key part of working with anxiety disorders (*"it's never easy seeing someone in distress but I know at a deeper level that this is likely to be worth it for them"*). During future supervision sessions (and indeed outside supervision also) David began to reflect on some of his beliefs about the role of distressing emotions in psychotherapy (not just in anxiety disorders but also in processing sadness and loss). He became more aware of his own beliefs about himself and some of the early experiences and subsequent motivations behind his decision to train as a counsellor. He began to notice other examples of how these beliefs manifested themselves in his therapy, such as avoiding silences that were uncomfortable for him (but were opportunities for client reflection and assimilation) and trying to do too much for the client (at the expense of their opportunities to increase their self-efficacy).

This example displays some of the key features of reflection in CBT supervision:

- A clear shared model between supervisor and supervisee
- The use of detailed information in various modalities (e.g. drawn from role play, imagery work or video material)
- The use of a variety of processes including self-reflection, reflection on practice, reflective conceptualization, planning and acting
- Attempts to use evidence-based supervision methods (despite current limited evidence-base)  
An atmosphere of acceptance created by the supervisor, with explicit validation of the emotional reactions and unhelpful thoughts of the supervisee
- A balance between an acceptance of thoughts and feelings of the supervisee and the promotion of more clinically functional alternatives

In the following section we will show how reflective skills developed in training and supervision can be implemented and utilized at the time when they are needed most - in session with the client.

## Reflection in session

### Clinical Example of a CBT Therapist using Reflective Skills

Schön (1983) made a distinction between ‘reflection-on-action’ and ‘reflection-in-action’ (see also ch 1, this book). Both are familiar processes for CBT therapists: they reflect on action usually through supervision or self-supervision, and, as they grow in skill, they become more able to make subtle reflection-in-action decisions during the ongoing flow of therapy.

As an illustration of therapist use of reflective skills in CBT, we have selected a case example of “Mark” from a recent chapter on the CBT treatment of post-traumatic stress disorder (Grey, 2007). Mark was savagely raped at gunpoint by two men. In this example, the therapist needed to use both self-reflective skills, and to reflect on clinical knowledge and skills in order to make an important intervention. The sequence of skills is illustrated in Table 1.

*Table 1 about here*

During preliminary sessions, Mark had described being terrified by the experience. In a reliving session, the therapist noticed [interpersonal perceptual skill] that at a certain point Mark went very quiet and glanced down for a few moments before continuing his narrative about being raped. As the therapist internally mirrored this response [self-reflection], he registered that this reaction was quite different from anxiety. After the session, the therapist asked “I’m wondering what went through your mind when you went quiet?” [standard CBT Socratic question – technical skill]. Mark remained silent. The silence reinforced the therapist’s hunch that Mark was feeling shame [reflection]. Based on his knowledge of the literature and clinical experience, the therapist tentatively suggested: “It’s very common for men who have been raped to get an erection themselves. Did this happen to you?” [conceptual knowledge]. Mark looked up surprised, and said “yes”. Mark was a heterosexual man – for him the meaning of the erection meant that he was gay, and he felt a deep sense of shame. The therapist again used his conceptual knowledge to normalize Mark’s experience: “Erection under these circumstances does not mean you are gay”. The therapist explained about typical physiological responses to rape; and in later sessions, he helped Mark to update the trauma memory using this new information.

This case illustrates well the reflective demands on the CBT therapist in more complex presentations. Picking up on subtle nonverbal cues, reflecting on their meaning, and engaging sophisticated formulation-based knowledge is part-and-parcel of the practice of CBT. The competent CBT therapist subtly interweaves reflective skills (self-reflection and reflection-on-practice) with formulation-based knowledge and procedural skills to make sophisticated interventions which draws on specialist CBT knowledge and uses the person-of-the-therapist system as a “reflective barometer” for mirroring the patient’s experience.

## Conclusion

In this chapter we have shown that reflection is at the heart of current CBT practice, supervision and training. Indeed, a recent paper on the future challenges for CBT has placed reflective practice in a central position for the development of CBT competences (Mansell, 2008). We would argue that reflective practice has always been an important component of mainstream CBT, but that the language of reflection has been lacking until recent years.

We have sought here to develop a more sophisticated conceptualization and definition of reflection within CBT; described the DPR model as a theoretical framework within which the roles of reflection can be formulated; explicated the existing evidence-base; and provided examples of reflection in CBT from training, supervision and clinical practice. Clearly, one of the next steps is to continue to build the evidence base.

Reflection, like counter-transference, is a term borrowed from another literature to describe phenomena for which CBT did not previously have adequate terms. However, these terms carry different meanings for different schools of therapy - as indicated in the present book. Not all of these meanings sit easily within the CBT framework. CBT is situated within a tradition of experimental science. One of our aims has been to "unfuzz" the language of reflection and interpret it within an information processing framework. Time will tell whether these attempts will be sufficient to satisfy the tastes of CBT therapists, or whether in time CBT therapists will replace the rather global term "reflection" with more specific descriptors of process.

## References

- Armstrong, P. V. & Freeston, M. H. (2006). Conceptualising and formulating cognitive therapy supervision. In N. Tarrow (Ed.) *Case formulation in cognitive behaviour therapy: The treatment of challenging and complex clinical cases*. London: Routledge.
- Beck, A. T., Freeman, A. M. and Associates (1990). *Cognitive therapy of personality disorders*. New York: Guilford.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.
- Beck, J. & Butler, A.C. (2005). Treating psychotherapists with cognitive therapy. In: J.D.Geller, J.C. Norcross & D.E. Orlinsky (Ed.) *The psychotherapist's own psychotherapy*. Oxford: Oxford University Press.
- Bennett-Levy, J. (2003). Reflection: a blind spot in psychology? *Clinical Psychology Forum*, 27, 16-19.
- Bennett-Levy, J. (2005). What role does the 'person of the therapist' play in therapist skill development? Empirical and theoretical perspectives. In: M. Jackson & G. Murphy (Eds.): *Theory and practice in contemporary Australian cognitive and behaviour therapy: Proceedings of the 28th National AACBT Conference* (p.32-37). Melbourne: Australian Association for Cognitive and Behaviour Therapy.
- Bennett-Levy, J. (2006). Therapist skills: A cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy*, 34, 57-78.
- Bennett-Levy, J. & 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., Butler, G., Fennell, M.J.V., Hackmann, A., Mueller, M. & Westbrook, D. (Eds.) (2004): *Oxford guide to behavioural experiments in cognitive therapy*. Oxford: Oxford University Press.
- Bennett-Levy, J., Lee, N., Travers, K., Pohlman, S., & Hamernik, E. (2003). Cognitive therapy from the inside: enhancing therapist skills through practising what we preach. *Behavioural and Cognitive Psychotherapy*, 31, 145-163.
- Bennett-Levy, J. & 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 & R. L. Leahy (Eds.). *The therapeutic relationship in the cognitive-behavioural psychotherapies*. London: Routledge.

- 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.
- Bolton, G. (2001). *Reflective practice: Writing and professional development*. London : Sage.
- Boud, D., Keough, H.R., & Walker, D. (1985). *Reflection: turning experience into learning*. London: Kogan Page.
- Chaddock, A., Thwaites, R., Freeston, M., & Bennett-Levy, J. (2006). Can Self-Practice/Self-Reflection enhance the therapeutic skills and attitudes of trainee Cognitive-Behavioural Therapists? EABCP Conference Presentation, Paris.
- Davis, M., Thwaites, R., Freeston, M., & Bennett-Levy, J. (2008). SP/SR with Experienced CBT Therapists: A measurable impact on beliefs and therapeutic skills. BABCP Conference Presentation, Edinburgh.
- Dewey, J. (1938). *Experience and education*. New York: Collier Books.
- Farrand, P., Perry, J., & Linsley, S. (2008). Enhancing SP/SR through the use of reflective blogs. BABCP Conference Presentation, Edinburgh.
- Grey (2007). Post-traumatic stress disorder. In S. Lindsay & G. Powell (eds.) *Handbook of clinical adult psychology, 3<sup>rd</sup> Edition*. London: Routledge.
- Haarhoff, B. (2006). The importance of identifying and understanding therapist schema in cognitive therapy training and supervision. *New Zealand Journal of Psychology*, 35, 126-131.
- Haarhoff, B. & Kazantzis, N. (2007). How to supervise the use of homework in cognitive behavior therapy: The role of trainee therapist beliefs. *Cognitive and Behavioral Practice*, 14, 325–332.
- James, I. A. & Allen, K. & Collerton, D. (2004). A post-hoc analysis of emotions in supervision: a new methodology for examining process features. *Behavioural and Cognitive Psychotherapy*, 32, 507-513.
- James, I.A., Blackburn, I. M., Milne, D.L. & Reichelt, F.K. (2001). *Manual of the Revised Cognitive Therapy Scale (CTS-R)*. Unpublished manuscript. Newcastle-upon-Tyne, UK: Newcastle Cognitive and Behavioral Therapies Centre and University of Newcastle-upon -Tyne.
- James, I. A., Milne, D. & Morse, R. (2008). Microskills of clinical supervision: scaffolding skills. *Journal of Cognitive Psychotherapy*, 22, pp. 29-36.
- Kemmis, S. & McTaggart, R. (1988). *The action research planner*. Victoria: Deakin University Press.
- Kolb, D. (1984). *Experiential learning*. Englewood Cliffs, NJ: Prentice-Hall.

- Laireiter, A., & Willutzki, W. (2003). Self-reflection and self-practice in training of cognitive behavioural therapy: an overview. *Clinical Psychology and Psychotherapy*, 10, 19-30
- Leahy, R. (2001). *Overcoming resistance in cognitive therapy*. New York: Guilford.
- Lewin, K. (1948). *Resolving social conflicts; selected papers on group dynamics*. Gertrude W. Lewin (ed.). New York: Harper & Row.
- Mansell, W. (2008). The seven C's of CBT: A consideration of the future challenges for cognitive behaviour therapy. *Behavioural and Cognitive Psychotherapy*, 36, 641-649.
- Milne, D. (2007). An empirical definition of clinical supervision. *British Journal of Clinical Psychology*, 46, pp. 437-447.
- Milne, D. L. (Submitted for publication). *Collusion in clinical supervision: Review and case study in self-reflection*.
- Milne, D. L. (2009). *Evidence-based clinical supervision: principles and practice*. Chichester: Wiley/Blackwell.
- Milne, D. L., Claydon, T., Blackburn, I. M., James, I. A. & Sheikh, A. (2001). Rationale for a new measure of competence in therapy. *Behavioural and Cognitive Psychotherapy*, 29, 21-33.
- Milne, D. L., James, I. A., Keegan, D. and Dudley, M. (2002). Teacher's PETS: a new observational measure of experiential training interactions. *Clinical Psychology and Psychotherapy*, 9, 187-199.
- Padesky, C. A. (1996). Developing cognitive therapist competency: Teaching and supervision models. In P. M. Salkovskis (Ed.), *Frontiers of cognitive therapy*. New York: Guilford .
- Safran, J.D. & Muran, J.C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford.
- Safran, J. D. & Segal, Z. V. (1996). *Interpersonal process in cognitive therapy (2nd ed.)*. Northvale, NJ: Aronson.
- Schön, D. (1983). *The reflective practitioner*. New York: Basic Books.
- Skovholt, T.M., & Rønnestad, M.H. (1992). Struggles of the novice counsellor and therapist. *Journal of Counseling & Development*, 70, 505-515.
- Sutton, L., Townend, M., & Wright, J. (2007). The experiences of reflective learning journals by cognitive-behavioural psychotherapy students. *Reflective Practice*, 8, 387-404.
- Thwaites, R. & Bennett-Levy, J. (2007). Making the implicit explicit: Conceptualising empathy in cognitive behaviour therapy. *Behavioural and Cognitive Psychotherapy*, 35, 591-612.

Thwaites, R., Chaddock, A. & Bennett-Levy, J., (2006). How does a manualised Self Practice/ Self Reflection (SP/SR) programme influence trainee CBT therapists' ability to work with interpersonal process? EABCP Conference Presentation, Paris.

Townend, M. (2008). Clinical supervision in cognitive behavioural psychotherapy: development of a model for mental health nursing through grounded theory. *Journal of Psychiatric and Mental Health Nursing*, 15, 328-339.

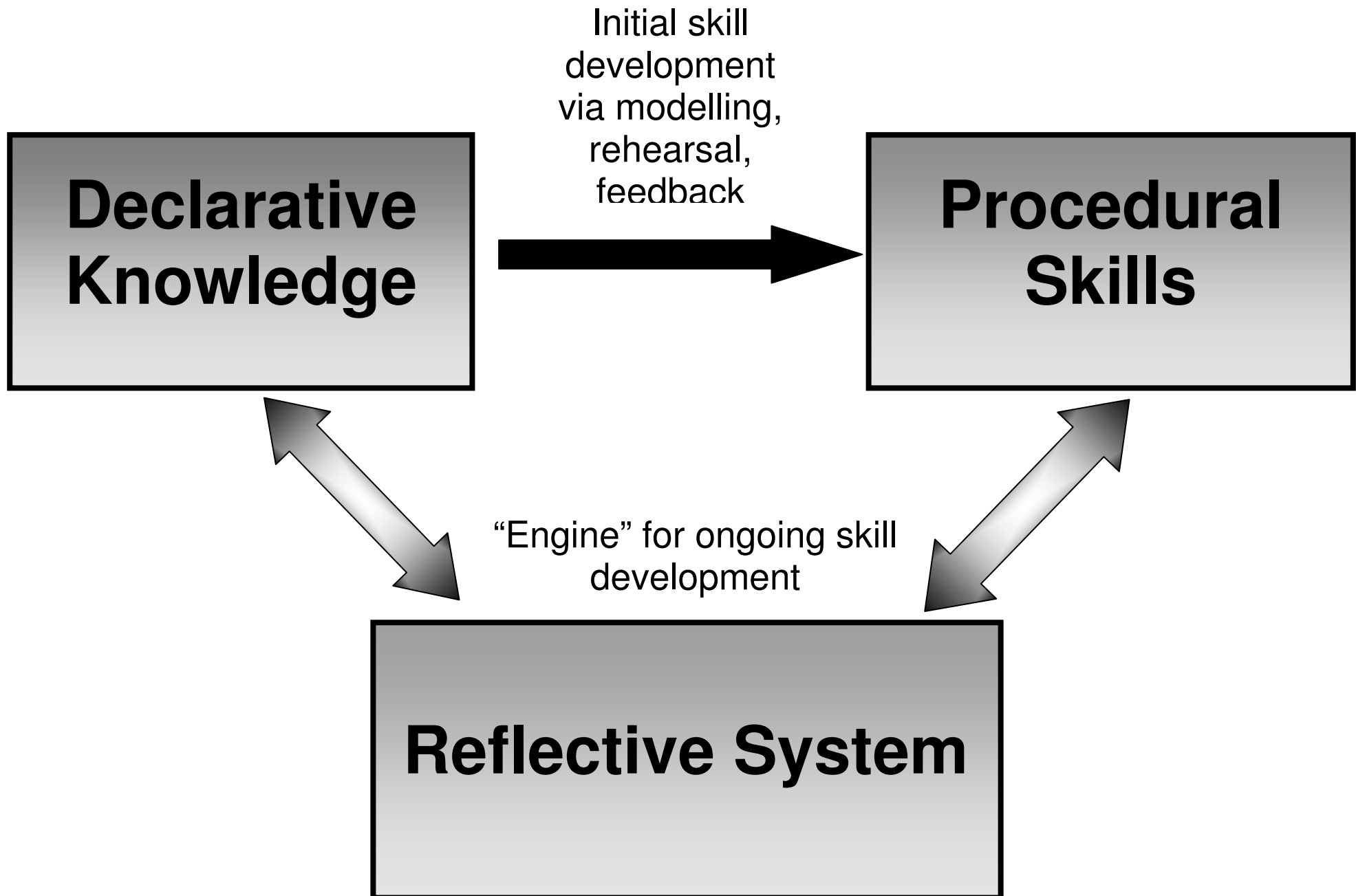
Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes*. Cambridge, MA: MIT Press.

Weissman, A. N., & Beck, A. T. (1978). Development and validation of the Dysfunctional Attitude Scale: A preliminary investigation. Paper presented at the meeting of the American Educational Research Association, Toronto, Ontario, Canada.

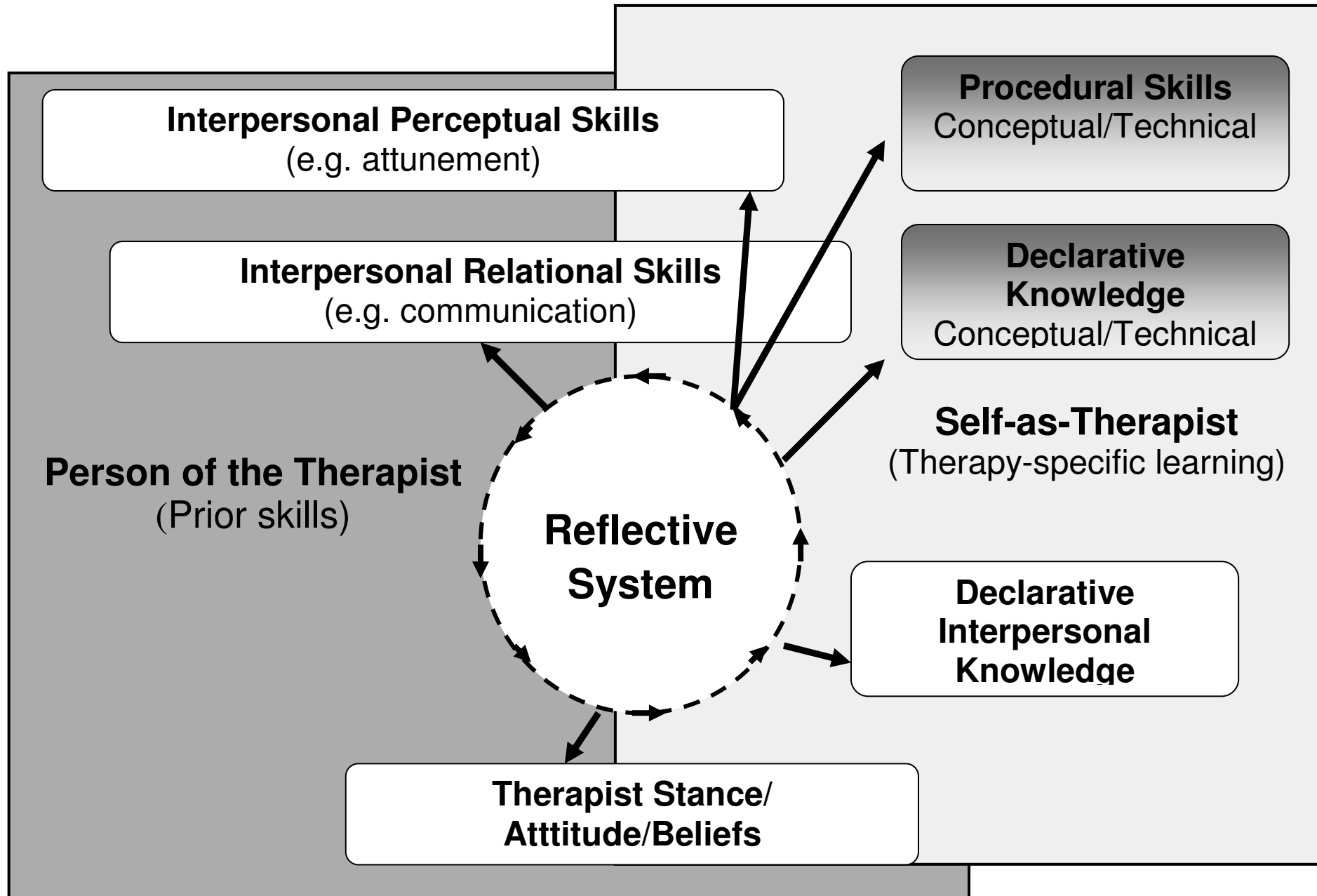
Young, J. E., & Brown, G. (2001). *Young Schema Questionnaire, special edition*. New York: Schema Therapy Institute.

**Acknowledgement:** We gratefully acknowledge Mark Freeston, whose skills as a reflective practitioner and researcher are embedded within some of the ideas in this chapter, and Nick Grey for kind permission to quote his case study.

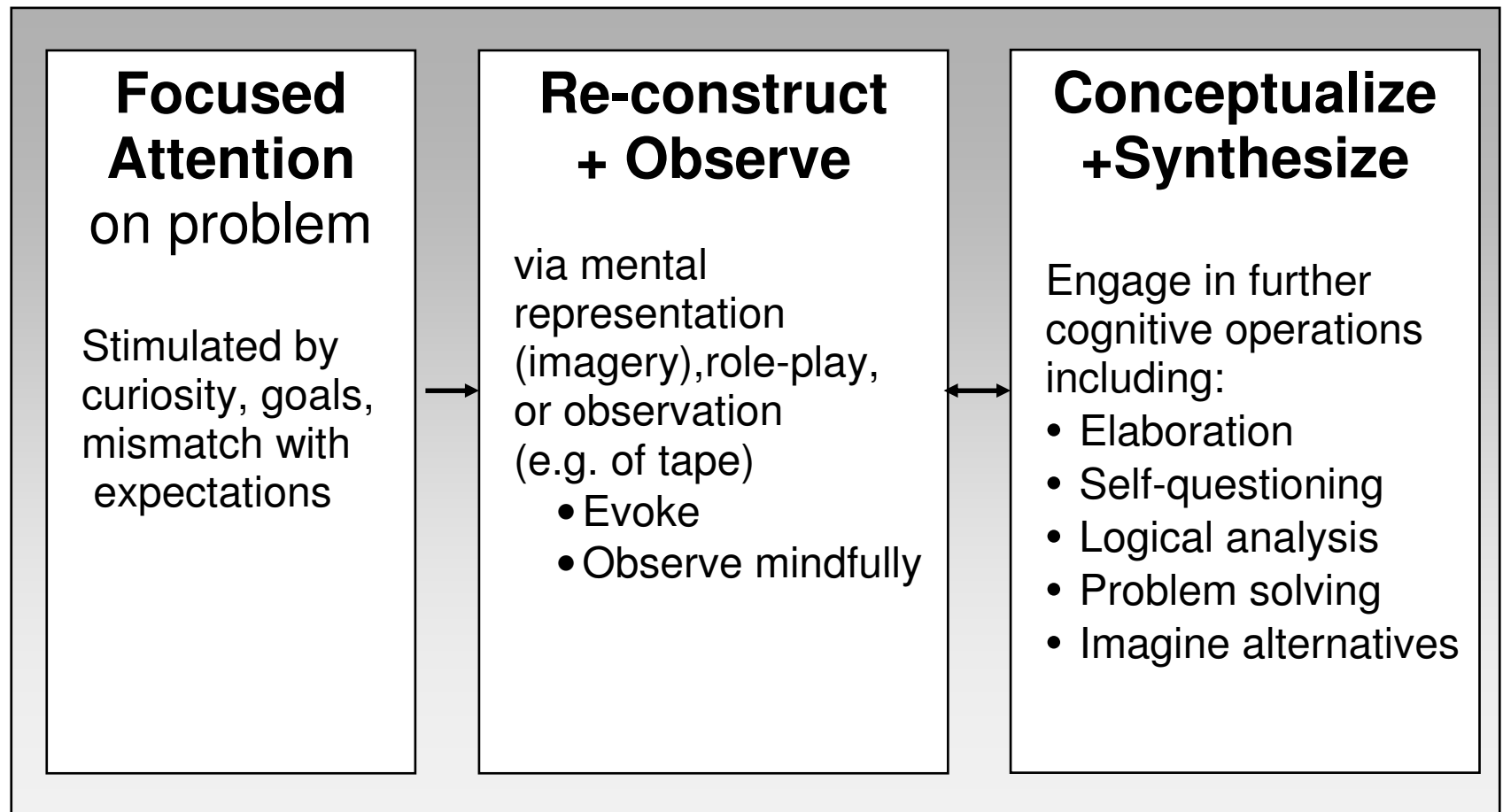
**Fig.1.** The Declarative-Procedural Reflective (DPR) Model



**Fig.2.** Another Perspective on the DPR Model highlighting the role of Reflection and Interpersonal Skills in Therapist Skill Development



**Fig 3:** The Reflective System: Key Elements of the Process



**Action Research terms:**

Observe

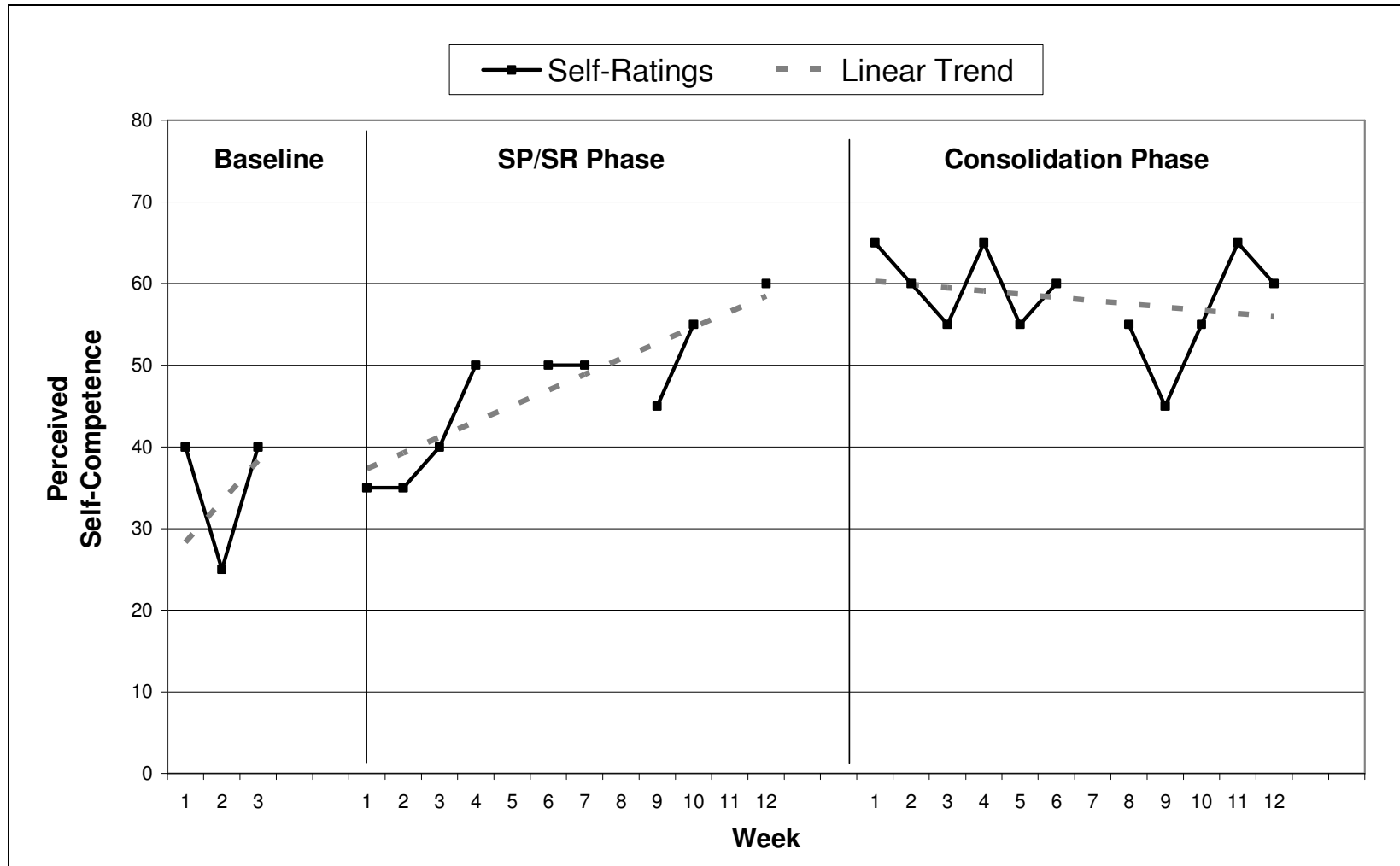
Reflect

**Kolb (1984) terms:**

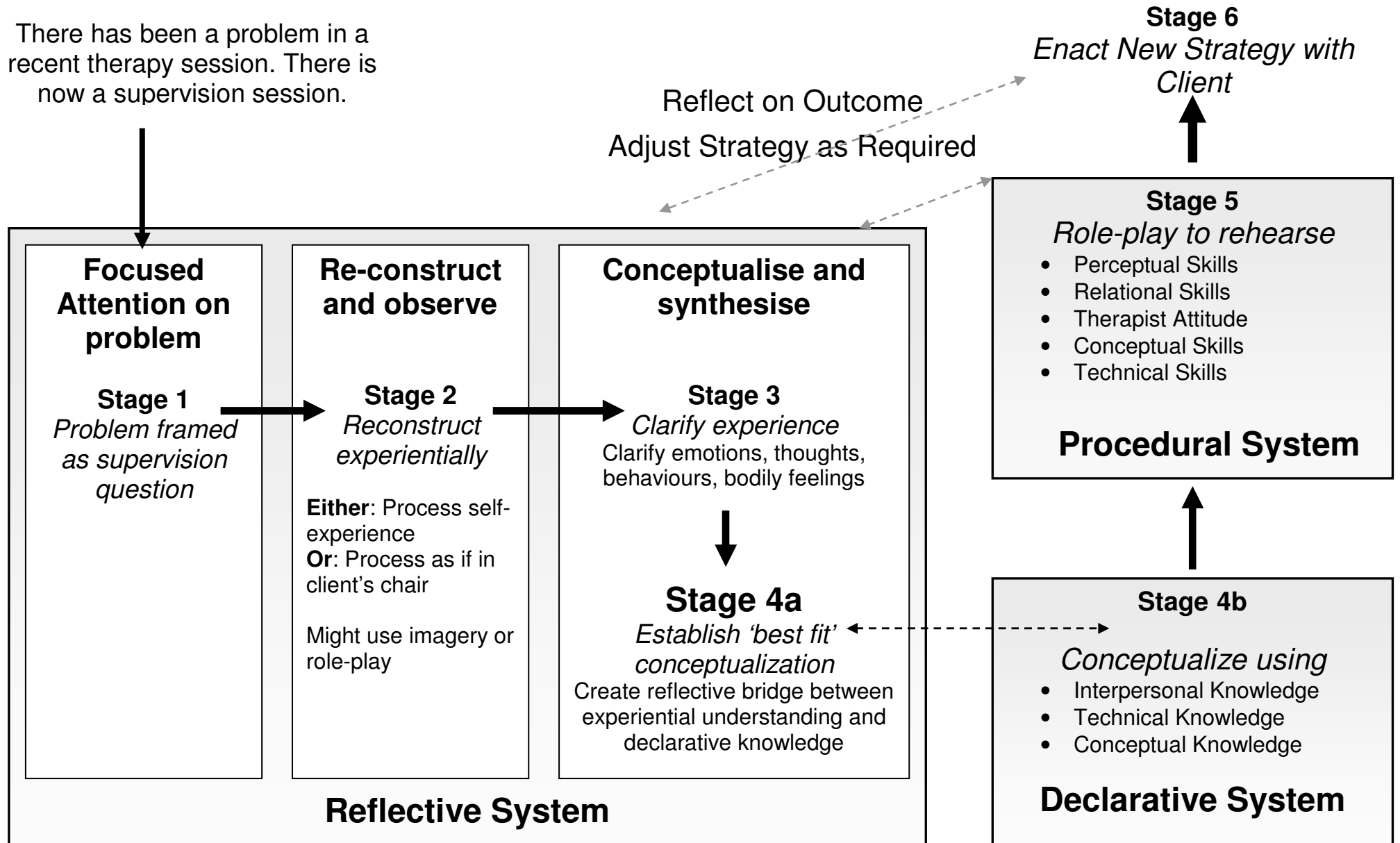
Reflective Observation

Abstract Conceptualization

**Figure 4:** Self-rated Guided Discovery Skills during Baseline, SP/SR and Consolidation Phases



**Figure 5:** The six-stage supervision process model (adapted from Bennett-Levy & Thwaites, 2007)  
 Heavy Arrows indicate progression through the stages. Light dotted arrows are further reflective processes.



**Table 1:** Sequence of Therapist Skills demonstrated in Clinical Example from Grey (2007)

<b>Therapist Reflections and Behaviours</b>	<b>Demonstrated Therapist Skills</b>
1. Therapist notices glance down	Interpersonal Perceptual Skill
2. Mismatch of nonverbal signal (glance down) with therapist expectation (terror signals). Uses self-schema (personal self) system to identify possible meaning of nonverbal response. Could this be shame?	Self-reflective Skill: (i) Reconstruct and Observe (ii) Conceptualize/synthesize
3. Asks classic Socratic question: " <i>What went through your mind just then?</i> "	Technical Skill
4. After silent response, further therapist reflection. Uses conceptual knowledge of PTSD to make educated guess.	General Reflection Skill: (i) Observe + (ii) Conceptualises using Conceptual knowledge
5. Normalises the experience	Conceptual knowledge and skills
6. Updates trauma memory	Conceptual and technical knowledge/skills