

## **Self and self-reflection in the therapeutic relationship**

**A conceptual map and practical strategies for the training, supervision and self-supervision of interpersonal skills**

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### **Introduction**

Many contributors to this volume have described the importance of the therapeutic relationship to outcome, and the complexities involved in developing and maintaining a therapeutic relationship. This chapter focuses on issues of training and supervision and asks: what training, supervision and self-supervision strategies may best facilitate the development and refinement of cognitive therapists' interpersonal skills? We approach these questions through the framework of a new cognitive model of therapist skill development, the declarative–procedural–reflective (DPR) model (Bennett-Levy, 2006), which:

- 1 enables therapists, trainers and supervisors to consider a variety of interpersonal factors and processes that go towards developing a positive, helpful therapeutic relationship
- 2 provides a conceptual map to pinpoint the particular area(s) of difficulty that may be causing a therapeutic relationship to deteriorate
- 3 identifies key learning processes and training strategies to enhance interpersonal skills and thereby refine therapeutic relationships.

Within this context, it is a further aim of the chapter to provide a coherent account that explains why interpersonal skill development differs from other forms of skill development (e.g., conceptual, technical) in cognitive therapy; and why *specific* training and supervision strategies are required to develop the interpersonal skills of cognitive therapists to best advantage. Much of the chapter focuses on these strategies; examples are provided.

The chapter is divided into six major sections. The first section outlines the DPR model of therapist skill development. The second section places the focus more specifically on the interpersonal skill components within the model. The third section describes the special role of the self, and self-reflection, in the refinement of interpersonal skills. The fourth section emphasizes the necessity of creating positive, supportive supervisory and

training relationships, and attending to process issues, if the trainees are to have sufficient confidence to address their therapeutic relationship issues in these contexts. The fifth section presents a six-stage process model for addressing therapeutic relationship difficulties, which we believe has wide application. The sixth section focuses on three learning contexts (training, supervision and self-supervision), and suggests which kinds of learning strategies (role-playing, didactic teaching, reflective practice, etc.) may be most appropriate for which types of interpersonal difficulty (perceptual skills, therapist attitude, etc.). We end by drawing the conclusion that if cognitive therapists wish to develop their therapeutic expertise and in particular their interpersonal skills across a range of client problems, then willingness to self-reflect and to develop the personal as well as the professional self is a prerequisite.

### **The declarative–procedural–reflective (DPR) model**

The aim of the DPR model is to provide a comprehensive model of therapist skill development (of any orientation) from an information-processing perspective. The model identifies and maps different elements of therapist skill and their relationship to one another, and suggests that different learning strategies are needed for different skills. Figure 12.1 illustrates the DPR model, and highlights those components particularly related to interpersonal skills.

In this section, the DPR conceptual framework is outlined (for a full description, see Bennett-Levy, 2006). We describe the three main information-processing systems (declarative, procedural and reflective), and focus on the key distinction between the self-schema and self-as-therapist schema. In the following two sections, we turn the spotlight more specifically onto the interpersonal elements of the model.

#### ***The declarative, procedural and reflective systems***

The *declarative system* contains the verbal propositional knowledge base for therapy. This is knowledge that we might write about, talk about or read about. Declarative knowledge is distinguished from procedural skills (see below), because at the declarative level, knowledge may be purely abstract; for example, the novice therapist who has read about cognitive-behavioural treatment for depression, but has not utilized the skills in practice. The model posits three basic kinds of knowledge within the declarative system: interpersonal, conceptual, and technical. For example, the *interpersonal knowledge* base about cognitive therapy might contain information about the value of the collaborative relationship; more advanced interpersonal knowledge might include understanding about therapeutic rupture markers (Safran & Muran, 2000).

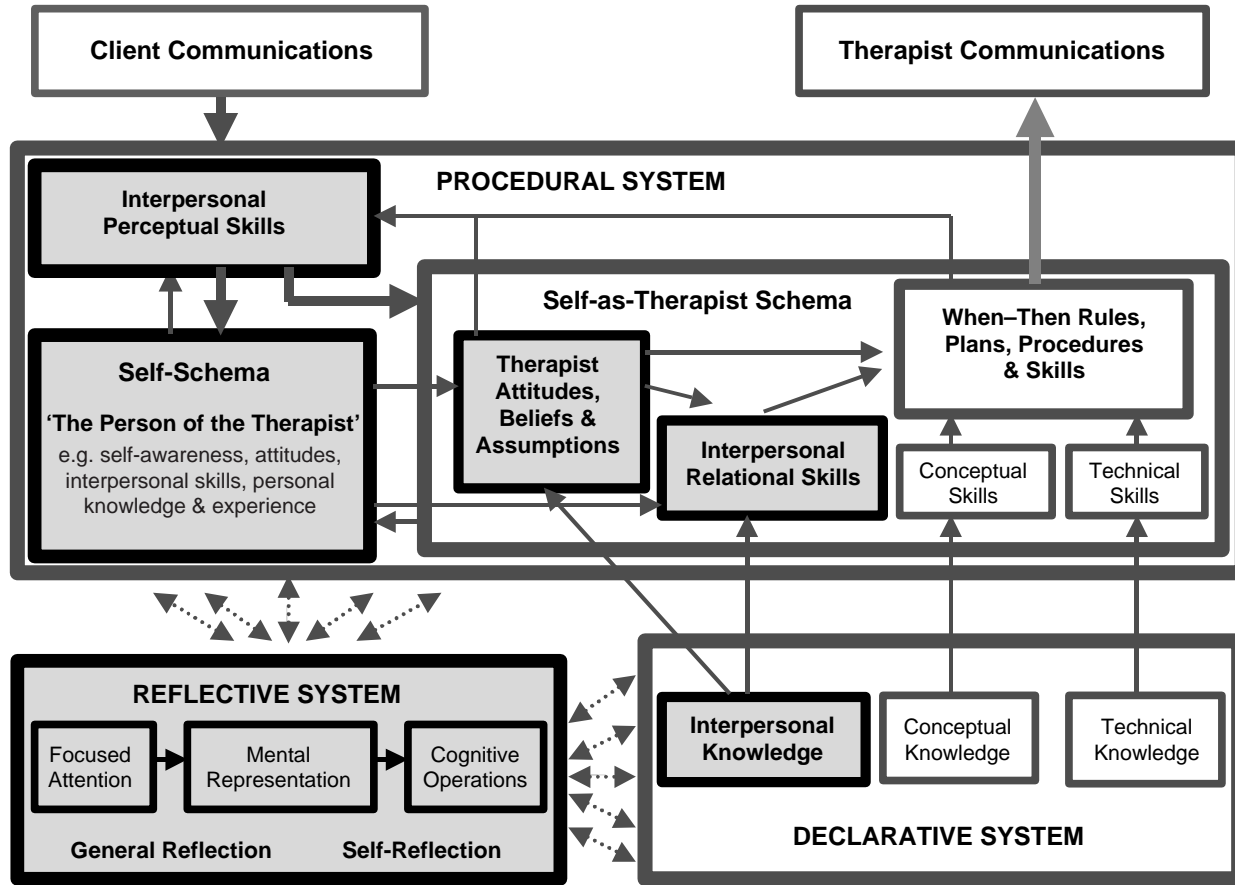


Figure 12.1 The DPR model of therapist skill development (adapted from Bennett-Levy, 2006). Components most centrally related to the acquisition and development of interpersonal skills, and to the therapeutic relationship, are highlighted.

The *procedural system* contains the often implicit storehouse of skills that are the manifestation of our declarative knowledge in practice. There are various procedural skill sub-components, some specifically oriented towards interpersonal skills (*interpersonal perceptual skills; therapist attitudes, beliefs and assumptions; interpersonal relational skills; self-schema*) – see next two sections – and some towards therapy-specific skills (*conceptual skills; technical skills*). Over time, skilled therapists are able to combine these sub-components into a largely automatized, implicit set of *when–then plans, rules, procedures and skills*, which can have an almost seamless appearance. These when–then rules enable us, for example, to decide with which client, at which point in time in therapy, with which kind of problem, it is most appropriate to use what kind of intervention, under what circumstances.

The reflective system is the third major system in the model. Unlike the declarative and procedural systems, the reflective system has no permanent knowledge or skill base and is a purely short-term representational system, which is created and dissolved in response to particular issues that require reflection. There are two broad types of reflection: *self-reflection*, where we reflect on our internal world, and *general reflection* (for example, reflection on technical skills – “did I use the best strategy to test the client’s belief?”), which has a more distanced, objective quality. As we shall describe in the third section, self-reflection is particularly important in the creation and maintenance of effective therapeutic relationships.

The reflective system is usually prompted into action by a particular problem that requires attention, by puzzlement or curiosity, or by a mismatch between expectations and reality (for example, the client has been unexpectedly distressed by what was meant to be a therapist compliment). Supervision is, *par excellence*, a time when the reflective system is typically operative.

The reflective system comprises three principal elements: *focused attention* on a particular problem, *mental representation* of that problem (previously termed *autonoetic consciousness*; Bennett-Levy, 2006), and a set of *cognitive operations* to try to resolve the problem. Guided discovery, Socratic questioning, and logical analysis are characteristic of the cognitive operations that supervisors and trainees typically use. The reflective system then “returns” the solution to declarative and/or procedural systems, perhaps leading to modification of declarative knowledge, or of when–then plans, rules, procedures and skills.

In essence, it is the reflective system that provides the ongoing dynamic for therapist skill development. As Schön (1983) and Skovholt (2001) have written, it is this process of reflection that, perhaps more than anything else, can help to move therapists from being average to expert, from being adequate technicians to being sophisticated, flexible and responsive practitioners.

### **Self-schema and self-as-therapist schema**

In the DPR model a distinction, which has important implications for interpersonal skills, is made between the personal (*self-schema*) and professional self (*self-as-therapist schema*) of the therapist. It is assumed that prior to becoming a therapist, we process information about the world through our self-schema. In the model, the self-schema contains our beliefs about ourselves, others and the world; our skills, our experience, our emotional intelligence, our values and so on. (In reality, the size of the self-schema is misrepresented in Figure 12.1 – it should dwarf the self-as-therapist schema and have numerous sub-components). As others have written (Gilbert, Hughes, & Dryden, 1989), and as we shall demonstrate below in the context of the DPR model, the “person of the therapist” exerts a profound influence on therapeutic process, over and above technical and conceptual proficiency.

When we train as therapists, we develop a new identity with some new beliefs and behaviours. This is the *self-as-therapist schema*. For instance, we develop new skills (e.g. *conceptual skills*, *technical skills*), which we (hopefully) tend not to use in non-therapy situations with friends or relatives, and we adapt our behaviour so that it is appropriate to the therapy milieu (for example, we do not discuss our own problems and expect the client to help us solve them). However, not all of our behaviours and skills are new. In particular, we carry with us our interpersonal skills, and some of the attitudes and values that may have been instrumental in our choice of profession (for example, compassion for people in distress) (Dryden & Spurling, 1989). Some therapists appear to start with an intrinsic advantage – people who have a “naturally” warm, empathic, compassionate stance (*therapist attitudes, beliefs and assumptions*), who can easily tune into where the client is at and pick up subtle nonverbal signals (*interpersonal perceptual skills*), and can communicate their empathy and concern in a collaborative – “let’s work on this together” – way (*interpersonal relational skills*). Other therapists may not have such natural advantages.

As various authors have noted (e.g. Bateman & Fonagy, 2004; Gilbert, 2005), social information processing is highly specialized. In the context of therapist skill development, the DPR model suggests that therapists’ interpersonal skills are distinguished from technical and conceptual cognitive therapy skills in several ways: first, by their recruitment of different information processing systems – specifically, their dependence on the *self-schema* and *self-reflection* (see the third section); and second, because they require specific training strategies (see the sixth section).

### **A specific focus on interpersonal skills**

Since this chapter is concerned with the development and refinement of interpersonal skills, we shall focus on the interpersonal skill components of

the model in more detail. Key elements here are: *interpersonal perceptual skills*, *therapist attitude*, *interpersonal relational skills*, and *interpersonal knowledge* (see Figure 12.1).

### **Interpersonal perceptual skills**

*Interpersonal perceptual skills* function as a filter that determines what information we pick up from the client and what we miss. They allow us to attune to the client's "in process" state (Greenberg & Goldman, 1988), as well as to focus on verbal and nonverbal indicators that enable us to create and gather evidence for our formulation.

Bennett-Levy (2006) suggested that perceptual skills comprise at least three partially overlapping skills: empathy, mindfulness, and reflection-in-action. Empathic attunement enables us to represent the client's experience internally within our own self-schema system, so that we can understand the nature and extent of the client's distress from the inside. Mindfulness enables us to engage in a form of double consciousness (Gabbard & Wilkinson, 1994) where we can attend to both the client's experience and our own (Katzow & Safran, Chapter 5, this volume; Safran & Muran, 2000). Reflection-in-action represents a level of skill which is sufficiently sophisticated that we are taking complex decisions about where to focus our attention, and what to do next, often out of conscious awareness.

Perceptual skills have received very little attention from cognitive therapists, possibly because these skills are difficult to measure. Yet arguably they are one of the most crucial elements of effective therapy (Greenberg & Goldman, 1988). Deficits or problems with perceptual skills can come from a variety of sources: for instance, novice therapists often do not have the attentional resource to focus on interpersonal skills as well as conceptual/technical skills, and tend to favour the latter; some may lack confidence and, like clients with social anxiety, focus their attention internally. Other therapists are simply "over-technical" (a commonly reported issue with cognitive therapists in former times) or lack capacity for empathic representation. Sometimes, where therapeutic ruptures occur, therapists may be hijacked by their own powerful countertransference reactions (Leahy, 2001; Safran & Muran, 2000).

### **Therapist attitudes, beliefs and assumptions**

*Therapist attitudes, beliefs and assumptions* encompass values, beliefs, and assumptions about self, clients, and the therapy process (see Leahy, 2001). Some therapist attitudes/beliefs/assumptions have a general impact on performance (for example, "I must get all my clients better"), and may lead to irritation, sense of failure or burnout. Some attitudinal issues are specific to particular client groups (for example, difficulty working with people who

get hostile, or with perpetrators of sexual assault), or to particular elements of the therapy process (for example, “I must be available for all of my clients all the time”). There are, of course, natural variations in therapist attitudes over time, often related to life or work issues (Bennett-Levy & Beedie, 2007). These can be explicitly addressed in supervision, as can the possible need for personal therapy. *Therapist attitudes, beliefs and assumptions* are likely to impact both on *perceptual skills* and on *relational (communication) skills*. As a number of chapters in this volume suggest, the stance of the therapist is fundamental.

### **Interpersonal relational skills**

The distinction within the model between perceptual and relational skills is that whereas the former are *receptive skills* focused on the client’s communications, the latter are *active therapist communication skills*, for instance the *expression* of empathy, warmth or compassion. Some relational skills are relatively simple; some undoubtedly complex. For instance, while some novice therapists may from the start have little difficulty in communicating genuineness or warmth, most therapists will require considerable training to acquire the kind of therapeutic rupture repair skills identified by Safran and colleagues (Katzow & Safran, Chapter 5, this volume; Safran & Muran, 2000). Although as indicated above, there are clear links between *relational skills* and *therapist attitudes and beliefs*, there are often disjunctions. Novice therapists sometimes need to learn that *feeling* empathic towards clients is not enough; there are skills that can be practised to *communicate* empathic understanding (Thwaites & Bennett-Levy, submitted for publication).

### **Interpersonal declarative knowledge**

At a declarative level, therapists need a conceptual understanding of the key elements of interpersonal processes; the role they play in successful therapy; and ways to conceptualize interpersonal difficulties. Indeed, the subject matter of this entire book is contemporary declarative understandings of the therapeutic relationship in cognitive therapy, plus a wealth of procedural tips (which remain declarative knowledge until enacted). However, only when these understandings and tips are taken on board and practised do they start to become part of a therapist’s procedural skills system.

Attitudinal or relational skill problems at a procedural level are often related to “person of the therapist” issues. However, sometimes they are simply a result of declarative knowledge deficits. For instance, at a basic level, if novice therapists do not understand the centrality of the collaborative approach in cognitive therapy, then they are unlikely to act collaboratively, or recognize the importance of acquiring the requisite technical knowledge and skills (for example, asking for client feedback). At a more

advanced level, in order to be able to provide clients with a convincing rationale for compassionate mind training, it may be helpful for therapists to understand social mentality theory and the affect regulation systems model (Gilbert, Chapter 6, this volume).

### **The particular relevance of the self-schema and self-reflection to interpersonal skill development**

In this section, we point to the particular contribution of the self-schema and self-reflection in the development of interpersonal skills, and suggest that it is this contribution that distinguishes interpersonal skills training from conceptual or technical skills.

#### ***The self-schema***

The DPR model suggests that the self-schema is directly linked to *interpersonal perceptual skills*, *therapist attitude* and *interpersonal relational skills* (see Figure 12.1). As noted above, interpersonal skills and beliefs are part of who we are in everyday life, and predate therapist training, so almost inevitably there is a significant carry-over into therapist interpersonal skills and beliefs. In this sense, the relationship of therapists' interpersonal skills to the self-schema is rather different from the relationship of conceptual and technical skills to the self-schema; conceptual and technical skills are almost entirely learned *de novo*.

The proposition that personal (self-schema) development is intrinsically related to therapists' interpersonal skills gains support from a number of studies (Bennett-Levy, Turner, Beaty, Smith, Paterson, & Farmer, 2001; Bennett-Levy, Lee, Travers, Pohlman, & Hamernik, 2003; Jennings & Skovholt, 1999; Laireiter & Willutzki, 2005; Machado, Beutler, & Greenberg, 1999; Rennie, Brewster, & Toukmanian, 1985). For instance, Machado *et al.* (1999) found that therapists' personal awareness of their own emotions had a positive impact on the accuracy of identifying the emotions of a videotaped client; and Jennings & Skovholt (1999) reported that master therapists had exceptional relational skills and at a personal (self-schema) level were highly self-aware, reflective, non-defensive, and mentally healthy and mature. At times, therapists may avoid personally experiencing certain emotions (e.g. grief), which pose a threat to their self-schema (for example, from their own unresolved experiences of loss), thus limiting the processing of particular types of information (Gilbert *et al.*, 1989; Safran & Greenberg, 1998). This can block communication around significant issues and therefore constitute a threat to the working relationship between therapist and client.

Of course from a clinical perspective, it makes sense that personal (self-schema) development is highly related to therapists' interpersonal skills and

attitudes, since issues such as lack of confidence (Bennett-Levy & Beedie, 2007) and the triggering of countertransference reactions (Leahy, 2001) are, of necessity, based in the therapist's personal (self-schema) experience.

### **Self-reflection**

The other system that has particular importance in the context of interpersonal skill development is the reflective system, comprising two broad types of reflection, *general reflection* and *self-reflection*. While a number of writers point to the importance of *general reflective* capability in the development of therapist skills, including interpersonal skills (Bennett-Levy, 2006; Bennett-Levy & Padesky, submitted for publication; Milne & James, 2002; Skovholt, 2001), here it is suggested that the capacity to *self-reflect* is one of the key elements that distinguishes the learning of sophisticated interpersonal skills from the learning of technical or conceptual skills.

The distinction between these two forms of reflection, and modes of processing, is important because some clients – and therapists – may be quite adept at reflecting in one mode (for example, reflecting on a conceptual issue), and quite avoidant or unskilled in the other (for example, reflecting on a personal, emotional issue). We propose that while both general reflective skills and self-reflection are important for interpersonal skill development, deficits in each have quite different implications for the supervision or training of therapist interpersonal skills (see “Learning strategies and types of interpersonal skill problem” below).

As discussed above, interpersonal skills may in large part derive from the self-schema and are usually tacit and highly automatized. Therapists may often be unaware of some of the subtler aspects of their nonverbal communication. If personal issues or interpersonal skill difficulties of which the therapist is either unaware or only partially aware are implicated in a therapeutic rupture, then self-reflection is a prime requirement. For some supervisees who are emotionally avoidant, or have little skill at taking an observer position on their own behaviour (Ladany, Friedlander, & Nelson, 2005), this may be deeply challenging. For example, we know of supervisees with rigid technical styles who have baulked at the prospect of engaging in self-reflective practice.

The implications for training and supervision of interpersonal skills are quite apparent. A focus on the personal as well as the professional self, and a capacity and willingness to self-reflect, are central aspects of therapist skill development. While other training strategies (observational learning, role-play, lectures, reading, etc.) and learning modes (role-play, general reflection) are as applicable to the development of technical or conceptual skills as to interpersonal skills, the particular focus on self-schema and self-reflection in interpersonal skill development is both central and unique.

## **Interpersonal process issues in the supervisory/training relationship**

In the following sections, we shall be addressing training and supervision strategies for developing and refining interpersonal skills. However, careful conceptualization of interpersonal problems and useful remediation strategies on their own are not enough. Training or supervision initiatives will be hindered unless trainees feel safe enough to discuss their therapeutic relationship difficulties. Ladany *et al.*'s (2005) suggestion about process in supervision is: "Do unto others as you would have them do unto others" (p. 215). Nowhere is this truer than when we are working with interpersonal skills.

Because perceptual or relational skill difficulties, and therapist attitudes, beliefs and assumptions, are more intrinsically tied to the self-schema than technical or conceptual skills, challenges in this domain are more emotionally sensitive, more personally felt. Furthermore, because we may experience interpersonal issues as just a vague sense of "something wrong" without a rudimentary hint of conceptualization, or because we may find ourselves tripped up time and again by an acknowledged difficulty (for example, staying calm in the face of anger), we can easily experience a feeling of foolishness, or a sense of embarrassment or shame.

The interpersonal process between the supervisor or trainer and the trainee is fundamental to effective interpersonal skills training. To create an environment in which such issues can be helpfully addressed, supervisors and trainers must model the process effectively, or trainees are likely to self-censor (Neufeldt, 1999). A sense of safeness (Gilbert, Chapter 6, this volume), non-judgemental acceptance, affirmation, empathy, care, warmth and encouragement to explore are prime requirements (Worthen & McNeill, 1996). Trainers and supervisors can assist trainees by normalizing interpersonal issues as something all therapists encounter, empathizing with the difficulty of acting effectively when emotions are aroused, acknowledging and validating their attempts to deal with the issue, and disclosing similar experiences of their own when appropriate (Worthen & McNeill, 1996). The sense of safeness is also enhanced by being clear about boundaries (for example, in supervision how to address interpersonal or personal issues, and when not to), confidentiality agreements (for example, on a training course when doing pairs work on interpersonal problems, who says what in a group discussion) and by the provision of a rationale for the focus on the experiential rather than purely the conceptual (Safran & Muran, 2000). Supervisors should model respect by seeking permission before addressing potentially sensitive self-schema issues, and openness by welcoming feedback from supervisees, in particular when things do not feel right.

These requirements underpin the discussion of training and supervision strategies below. For instance, trainees are unlikely to engage fully in an

experiential training programme where they practise cognitive therapy techniques on themselves unless their doubts are welcomed and addressed, the conditions are collaboratively negotiated, and confidentiality agreements are clear (Bennett-Levy *et al.*, 2001). Similarly, supervisees who feel that they may be negatively judged are likely to be reluctant to raise interpersonal difficulties with their supervisor (Ladany *et al.*, 2005). Further suggestions about process issues are contained in Table 12.1.

### **A six-stage process model for addressing therapeutic relationship difficulties**

In Figure 12.2, we present a six-stage model for addressing therapeutic relationship difficulties developed from examples in the literature, consultation with colleagues, and our own practice. We suggest that the model has particular applicability for supervision, and may also be used in self-supervision and training contexts.

The six stages are mapped out in Figure 12.2. The supervisee arrives for a supervision session, having recently experienced an interpersonal problem with a client. The issue may be quite clear, or it may be felt as a vague sense of unease in need of clarification. At Stage 1 (*focused attention* – first part of the reflective system; see Figure 12.1), the problem is raised and becomes a focus for reflection in the session.

At Stage 2 (*mental representation*), the issue is brought to mind. Here the supervisor helps the supervisee to evoke a direct experiential awareness of the feelings, thoughts and behaviours activated at the time of the session. This typically takes one of two forms. In the first procedure, the supervisor helps the supervisee to reconstruct his/her experience in the therapist's chair; it is often helpful to use role-play or imagery to bring the feelings back to life. A second procedure – especially useful when there is a strong countertransference reaction and the supervisee appears blind to the client's experience – is for the supervisee to use his/her self-schema reaction to process the situation as if in the client's chair. Here, the supervisor role-plays the therapist, and the supervisee the client.

At Stage 3 (*cognitive operations: clarify experience*), the supervisor helps the supervisee reflect on the experience in the therapist's or client's chair, still in a subjective, experiential, how-it-felt mode. Here the purpose is to clarify their understanding of the emotions and cognitions they experienced; to move from vagueness to clarity, or from knee-jerk reaction to experiencing the underlying feelings.

At Stage 4 (*cognitive operations: conceptualize using declarative system*), there is a shift in mode of processing from the primarily subjective, experiential mode of Stage 3 to a more objectifying conceptual-analytic stance. The Reflective System (Stage 4a) engages with the declarative system (Stage 4b) to create a "reflective bridge", using the enhanced experiential

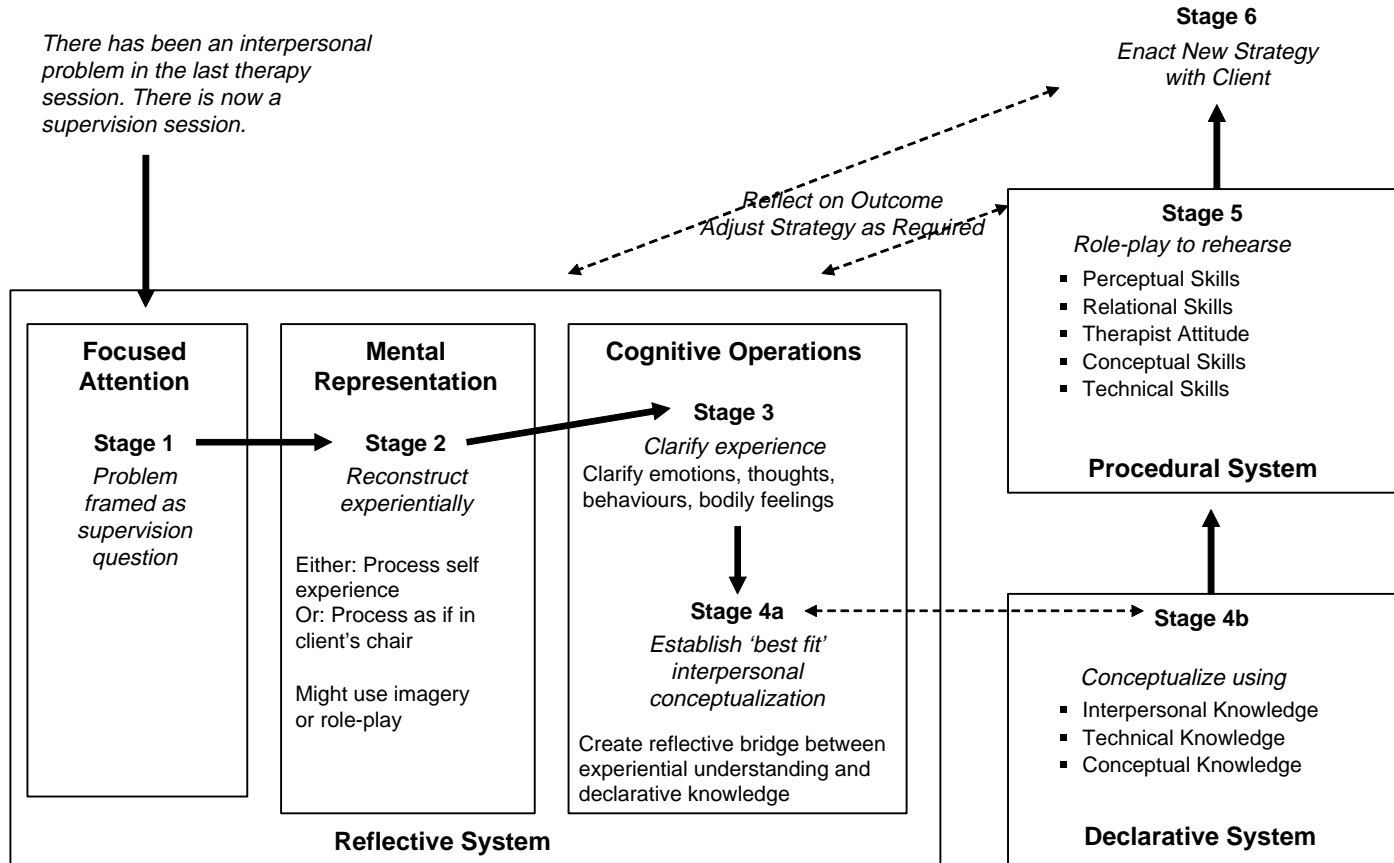


Figure 12.2 The six-stage process model for addressing therapeutic relationship difficulties (solid arrows indicate progression through the stages; broken arrows are reflective processes).

understanding together with declarative knowledge to create an interpersonal conceptualization of the difficult interaction. Movement from Stage 3 to Stage 4 is what Safran & Muran (2000) term “disembedding” from the experience, adopting a metacognitive perspective. Due to the emotion aroused by the difficult therapy session, and the subjective mode of processing in Stages 2 and 3, the supervisor is often particularly helpful in helping to shift modes of processing between Stages 3 and 4.

Once the situation has been conceptualized, using interpersonal and conceptual knowledge, the situation can be role-played to put the appropriate procedural skills into practice (Stage 5). When these have been adequately refined, they can be tried out with the client (Stage 6). At Stages 5 and 6, supervisee and supervisor reflect on the experience of the role-play or on the actual experience with the client, and adjust procedural skills accordingly.

To bring the model to life, below we give a specific example from a supervision session.

### ***Stage 1: Focus on and frame the problem***

Terry, the supervisee, came to his supervision session concerned that his depressed client, Mary, was not making the progress that might have been expected. Listening to an audiotape of a recent session, it became clear to Terry and his supervisor Jane that as soon as Mary started crying, he moved hastily into problem-solving mode. Terry said this often occurred in their sessions.

### ***Stage 2: Evoke mental representation of the experience***

Jane suggested a reverse role-play, where she role-played Terry in his problem-solving mode and Terry moved into the client’s chair as Mary.

### ***Stage 3: Clarify the experience***

When Terry experienced the rush into problem-solving mode for himself, he reflected that he found it hurtful and invalidating, and withdrew emotionally.

### ***Stage 4: Conceptualize the experience***

Jane and Terry were now able to use this experience to derive an interpersonal formulation that identified the particular behaviours that Mary’s crying “pulled” from Terry; the impact of the rush to problem-solving on Mary’s sense of being heard and validated; her emotional withdrawal; and the effect on the relationship, collaboration and homework compliance.

They used the formulation, and other interpersonal and technical knowledge, to identify more helpful procedural skills that Terry could try out.

### **Stage 5: Practise procedural skills**

Terry and Jane now did several role-plays. With Terry in the therapist's chair, and Jane role-playing Mary, Terry practised first responding empathically and validating Mary's distress before moving into a collaborative formulation and problem-solving mode. Jane gave Terry feedback about her experience in the client's chair after each role-play, and they discussed what adjustments might enhance Terry's skills further.

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

Terry tried the new strategy with Mary with immediate positive results.

At all stages, reflection was intrinsic to the process, as identified by the broken arrows in Figure 12.2. It is also worth noting that the process continued beyond Stage 6.

### **Beyond Stage 6**

Terry confided to Jane that he tended to rush into problem-solving mode with other clients as well. Jane asked what could be behind this thinking. Terry said that for as long as he could remember, he'd felt uncomfortable when people were upset (*self-schema* emotional activation). He had implicit rules that he was there to help people, not to cause pain (*self-schema* rule, now translated into a *therapist attitude/belief*), and as a therapist that it might be dangerous to his clients to stick with upsetting things (*therapist attitude/belief*). Jane suggested that for Terry to change these feelings and rules, it might be useful for him to explore their derivation in his personal history (*self-schema*), and consider how he would like to feel instead. He might then develop and test out some more adaptive rules (further reflection on *self-schema*, develop new rules, behavioural experiments with new rules).

This example demonstrates the close links between interpersonal difficulties and the self-schema, and why there is often a need for therapists to self-reflect and engage in further self-schema work to address interpersonal problems, using strategies such as self-practice/self-reflection or personal therapy (see next section).

## **Learning strategies and types of interpersonal skill problem**

In this section, we highlight some of the strategies that cognitive therapists currently use to develop and refine their interpersonal skills, which are crucial to the therapeutic relationship, and point to some new possibilities. We suggest that some strategies (for example, emotion recognition training) are particularly appropriate for certain types of interpersonal skill problem (for example, interpersonal perceptual skills), and less so for others (for example, general reflection deficit); however, other learning strategies (for example, reflective practice) may have broad applicability.

Table 12.1 links strategies to types of problem, and provides the framework for the following discussion. It contains many suggestions, some empirically supported, some more speculative. A detailed discussion of each element is beyond the scope of the chapter. In this section, we focus on the three key strategies that we believe impact significantly at *most* levels of interpersonal skill: reflective practice, self-practice/self-reflection and role-playing. We then briefly discuss the value of other common training strategies (didactic presentations, demonstrations/observational learning) and aids to supervision (use of videotapes and audiotapes). For perceptual skills training, we speculate that there may be useful training strategies specific to these skills. Finally we highlight the fact that interpersonal skills may be significantly impaired when clinicians have personal (self-schema) problems or deficits in reflective function.

### **Reflective practice**

Within the context of the DPR model, we use the term “reflective practice” to refer to the activity of reflecting on clinical experience, including our personal reactions, attitudes and beliefs, with the purpose of enhancing our declarative knowledge and procedural skills. Reflective practice is the self-supervision cornerstone of our day-to-day development as therapists. It is also the quintessential characteristic of good supervision, with the added advantage that the supervisor can ask Socratic questions, provide declarative information and stimulate reflection that is beyond the internal frame of reference of the supervisee. As noted in the first and third sections, and Table 12.1, reflection is a particularly important component in the refinement of interpersonal skills.

Reflective practice requires certain practitioner qualities, as well as an understanding of its rationale: “The ability to reflect upon one’s own practice requires self-awareness, honesty and insight into one’s values and attitudes, and an understanding of what it is that one is trying to achieve. To then utilize such reflection in the development of one’s clinical practice requires flexibility, adaptability and a willingness to accept that the work one is doing

**Table 12.1** Problem areas and some suggested self-supervision, supervision and training strategies: declarative knowledge and perceptual skills

	<i>DECLARATIVE KNOWLEDGE</i>	<i>PERCEPTUAL SKILLS</i>
Examples of markers of the problem	<p><b>Tape observation</b></p> <ul style="list-style-type: none"> <li>e.g. Therapist does not appear to understand role of collaboration in CBT</li> </ul> <p><b>Therapist report</b></p> <ul style="list-style-type: none"> <li>Therapist is aware of, but unable to conceptualise interpersonal problems e.g. <i>"I can't understand why I feel so angry with this client"</i> e.g. <i>"Something about the sessions just doesn't feel right"</i></li> </ul>	<p><b>Client feedback</b></p> <ul style="list-style-type: none"> <li>Feeling not heard or understood</li> </ul> <p><b>Tape observation</b></p> <ul style="list-style-type: none"> <li>Therapist not picking up on emotional states of client (e.g. unacknowledged shame)</li> <li>Nonverbal behaviour of client (e.g. emotional withdrawal)</li> <li>Inappropriate use of relational skills or deficits may indicate problems at a perceptual skill level</li> </ul>
Self-supervision strategies	<p><b>Reflective practice</b></p> <ul style="list-style-type: none"> <li>e.g. Theory-based conceptualisation</li> </ul> <p><b>Self-directed reading</b></p> <ul style="list-style-type: none"> <li>Basic interpersonal knowledge, e.g. role of collaboration</li> <li>Complex interpersonal knowledge, e.g. Safran &amp; Segal (1990) model of interpersonal process</li> </ul>	<p><b>Reflective practice</b></p> <ul style="list-style-type: none"> <li>Including review of tapes of own sessions, focusing on client's emotional state moment-to-moment</li> </ul> <p><b>Mindfulness practice</b></p>
Supervision strategies	<p><b>Supervisor-directed reading</b></p> <p><b>Didactic teaching</b></p> <p><b>Role playing</b></p> <ul style="list-style-type: none"> <li>Supervisor role plays client then supervisee formulates</li> </ul>	<p><b>Tape review</b></p> <ul style="list-style-type: none"> <li>With appropriate reflection on client communications (including nonverbal)</li> <li>Practice recognition of emotional state of client</li> </ul> <p><b>6-Stage process model</b></p> <p><b>Interpersonal process recall</b></p>
Training strategies	<p><b>Didactic teaching</b></p> <p><b>Role playing</b></p> <p><b>Modelling/observational learning</b></p> <p><b>Problem-based learning</b></p>	<p><b>Emotion and nonverbal communication recognition training</b></p> <p><b>Role playing</b></p> <p><b>Self-practice/self-reflection</b></p> <p><b>Modelling/observational learning</b></p>
Relevant process issues	<p><b>Sensitive/non-shaming questioning to identify knowledge deficits</b></p> <ul style="list-style-type: none"> <li>Bringing to awareness</li> <li>Build on current declarative knowledge</li> </ul>	<p><b>Sensitivity</b></p> <p><b>Explicit agreement/contracting</b></p> <ul style="list-style-type: none"> <li>Confidentiality</li> <li>Implications for joint/group supervision</li> </ul>

Table 12.1 (continued) Problem areas and some suggested self-supervision, supervision and training strategies: therapist attitude and relational skills

	ATTITUDES/BELIEFS/ASSUMPTIONS	RELATIONAL SKILLS
Examples of markers of the problem	<p><b>Client feedback</b></p> <ul style="list-style-type: none"> <li>• In-session feedback (e.g. "It feels as if you don't care about my problems")</li> <li>• Formal complaints</li> </ul> <p><b>Tape observation</b></p> <ul style="list-style-type: none"> <li>• Could be identified by verbal content, tone of voice, nonverbal communication</li> </ul> <p><b>Therapist report</b></p> <ul style="list-style-type: none"> <li>• Awareness of a difficulty in empathising with a particular client</li> </ul> <p><b>Rigid gender- or culture-based assumptions</b></p>	<p><b>Tape observation</b></p> <ul style="list-style-type: none"> <li>• Absence of, or poor skills in, establishing or maintaining a therapeutic relationship</li> </ul> <p><b>Client behaviour</b></p> <ul style="list-style-type: none"> <li>• Early termination of therapy</li> <li>• Resistance to procedure (e.g. not completing homework)</li> </ul>
Self-supervision strategies	<p><b>Reflective practice</b></p> <ul style="list-style-type: none"> <li>• Emotion as a guide</li> </ul> <p><b>CBT techniques to identify and test therapist beliefs/rules</b></p> <ul style="list-style-type: none"> <li>• Automatic thought records</li> <li>• Behavioural experiments</li> <li>• Self-Socratic questioning</li> </ul>	<p><b>Reflective practice</b></p> <ul style="list-style-type: none"> <li>• Including review of tapes of own sessions focusing on therapist's relational skills</li> <li>• Imaginal work – being in the client's chair</li> </ul>
Supervision strategies	<p><b>Identify type of attitudinal difficulty</b></p> <ul style="list-style-type: none"> <li>• Therapist belief questionnaires</li> <li>• Distinguish between general attitude, problem-specific (e.g. depressed clients) or client-specific</li> <li>• Distinguish between temporary problem (e.g. life issue) vs. personality problem</li> </ul> <p><b>6-Stage process model</b></p>	<p><b>Tape review</b></p> <ul style="list-style-type: none"> <li>• With feedback and reflection</li> </ul> <p><b>Role playing</b></p> <p><b>Supervisory relationship</b></p> <p><b>Modelling</b></p> <p><b>6-Stage process model</b></p> <p><b>Interpersonal process recall</b></p>
Training strategies	<p><b>Self-practice/self-reflection</b></p> <p><b>Role playing</b></p> <p><b>Modelling/observational learning</b></p>	<p><b>Role playing</b></p> <ul style="list-style-type: none"> <li>• Microcounselling training</li> </ul> <p><b>Self-practice/self-reflection</b></p> <p><b>Modelling/observational learning</b></p>
Relevant process issues	<p><b>Particularly sensitive as may be closely related to self-schema</b></p> <p><b>Boundaries</b></p> <ul style="list-style-type: none"> <li>• e.g. Regarding which personal issues are discussed in supervision and which require personal therapy</li> </ul>	<p><b>Supervisor aware of own assumptions regarding supervisee relational skills</b></p> <ul style="list-style-type: none"> <li>• e.g. General training issue or quality control for exceptions?</li> </ul> <p><b>Overcoming therapist resistance to role plays within supervision</b></p> <ul style="list-style-type: none"> <li>• Normalise anxiety</li> <li>• Provide rationale</li> <li>• Self-disclosure</li> <li>• Supervisor initially model therapist role</li> </ul>

Table 12.1 (continued) Problem areas and some suggested self-supervision, supervision and training strategies: general reflection and self-reflection

	<i>GENERAL REFLECTION</i>	<i>SELF-REFLECTION</i>
Examples of markers of the problem	<p><b>Curiosity not aroused by therapeutic anomalies</b></p> <p><b>Difficulty bringing to mind therapeutic incidents</b></p> <p><b>Absence of self-Socratic questioning</b></p> <p><b>Problems with conceptual or abstract thinking</b></p>	<p><b>Difficulty or unwillingness to reflect on own beliefs, feelings or contribution to the therapeutic relationship</b></p> <ul style="list-style-type: none"> <li>• e.g. Emotional avoidance</li> <li>• Difficulty tolerating own emotions</li> <li>• Inexperienced therapist with high levels of anxiety</li> <li>• External attributions regarding therapeutic process</li> </ul>
Self-supervision strategies	<p><b>Reflective practice</b></p> <ul style="list-style-type: none"> <li>• Reflective writing, e.g. session review</li> <li>• Self-evaluation of tapes of sessions</li> <li>• Actively seeking client feedback</li> <li>• Putting oneself in the client's shoes</li> <li>• Identifying gaps in knowledge</li> </ul> <p><b>Mindfulness practice</b></p>	<p><b>Reflective practice</b></p> <ul style="list-style-type: none"> <li>• Reflective writing about own feelings, thoughts and behaviours</li> </ul> <p><b>Self-practice/self-reflection</b></p> <p><b>Mindfulness practice</b></p>
Supervision strategies	<p><b>Detailed session notes</b></p> <p><b>Preparation for supervision</b> (e.g. identify question)</p> <p><b>Role playing + reflection</b></p> <p><b>Attentional shift to arouse curiosity</b> (e.g. identify one surprising aspect of each session)</p> <p><b>Reflective writing</b></p>	<p><b>Socratic questioning in supervision</b></p> <p><b>Interpersonal process recall</b></p>
Training strategies	<p><b>Self-practice/self-reflection</b></p> <p><b>Problem-based learning</b></p> <p><b>Reflective work sheets</b></p> <p><b>Role playing</b></p>	<p><b>Self-practice/self-reflection</b></p> <p><b>Reflective worksheets</b></p> <ul style="list-style-type: none"> <li>• To facilitate internalisation of reflective structure</li> </ul> <p><b>Role playing</b></p>
Relevant process issues	<p><b>Provide clear rationale/framework (declarative knowledge)</b></p> <p><b>Sensitivity/tact</b></p> <p><b>Explicit agreement/contracting</b></p> <ul style="list-style-type: none"> <li>• Confidentiality and implications for joint/group supervision</li> </ul> <p><b>Major reflective deficit – consider suitability for profession?</b></p>	<p><b>Provide clear rationale/framework (declarative knowledge)</b></p> <p><b>Sensitivity/tact</b></p> <p><b>Explicit agreement/contracting</b></p> <ul style="list-style-type: none"> <li>• Confidentiality and implications for joint/group supervision</li> </ul> <p><b>Contextual factors</b></p> <ul style="list-style-type: none"> <li>• Is self-reflection mandatory?</li> <li>• Quality of supervisory relationship</li> <li>• Institutional/service parameters</li> <li>• Personal resources</li> </ul>

*Table 12.1* (continued) Problem areas and some suggested self-supervision, supervision and training strategies: the self-schema (person of the therapist)

<i>SELF-SCHEMA</i>	
Examples of markers of the problem	<p><b>Self-confidence problems</b></p> <p><b>Emotional exhaustion/vicarious trauma</b></p> <p><b>Personality problems</b></p> <p><b>Counter transference/interpersonal schema activated</b></p> <ul style="list-style-type: none"> <li>• Unusual or strong emotional reactions, e.g. attraction to clients, anger, frustration</li> </ul>
Self-supervision strategies	<p><b>Reflective practice</b></p> <p><b>Personal therapy</b></p> <p><b>Self-practice/self-reflection</b></p> <p><b>Personal growth strategies</b> (e.g. psychodrama, yoga)</p>
Supervision strategies	<p><b>Awareness raising</b></p> <p><b>Attentional refocus</b></p> <p><b>Normalising</b></p> <p><b>Therapist self-care</b></p> <p><b>Identify need for personal therapy</b></p> <p><b>6-Stage process model</b></p>
Training strategies	<p><b>Self-practice/self-reflection</b></p> <p><b>Mindfulness practice</b></p>
Relevant process issues	<p><b>Provide clear rationale/framework (declarative knowledge)</b></p> <p><b>Sensitivity/tact</b></p> <p><b>Explicit agreement/contracting</b></p> <ul style="list-style-type: none"> <li>• Confidentiality and implications for joint/group supervision</li> </ul> <p><b>Awareness of supervisor responsibilities</b></p> <p><b>Boundaries</b> e.g. Regarding which personal issues are discussed in supervision</p>

may benefit from this process” (Cushway & Gatherer, 2003, p. 9). Possible strategies to enhance reflective practice include: reflective writing, self-evaluation of tapes and sessions, actively seeking and using client feedback, using supervision to maximum effect by preparing well and seeking help with difficult or uncomfortable issues, putting oneself in the client’s shoes, continuing to reflect on client conceptualizations between sessions, and seeking out relevant literature when identifying gaps in knowledge and skills.

Reflective writing (Bolton, 2005) soon after sessions, particularly difficult ones, can be an effective practice. As an example, below is an excerpt from Susan’s writing after a difficult session with a rigid emotionally controlled client:

I think I got it wrong this session. It was not collaborative. I took her somewhere she had expressly said she didn’t want to go [revisiting the break-up of a past relationship]. I did not respect her wishes. Why did I do it? Because it seemed to me that at some level her continued love for Harry was ridiculous, absurd. Why is she idolizing him? Is it like my experience with Ben? . . . [reflects on similarities and differences of own experience with former partner, and draws the conclusion that problematic self-schema beliefs of her own were activated in a counter-transference reaction to the client’s experience] . . .

I think I should start next week with apologising. I think I made a wrong move. It might work out OK in the end, but for now we need to work more gently. She has avoided emotions for many years, so to open them up like this was too much. Let’s go for looking at the future, who she was then, and who she might yet become.

### ***Self-practice/self-reflection (SP/SR)***

Self-practice/self-reflection (SP/SR) refers to a structured training experience in which trainees practise cognitive therapy techniques on themselves (SP), and then do written reflections (SR) focused on (i) their experience, (ii) its implications for their clinical practice, and (iii) the implications for cognitive theory (Bennett-Levy *et al.*, 2001, 2003). Two forms of SP/SR have been developed: one where trainees practise on their own via a structured workbook, and one where they engage in a limited “co-therapy” relationship, typically over four to six sessions each way.

Participants report a wide range of changes in the declarative understandings and procedural skills of cognitive therapy (Bennett-Levy *et al.*, 2001), and in their self-concept (e.g. confidence as therapist). More specifically, with regard to the present chapter, it has been suggested that the *prime* impact of SP/SR is on interpersonal skills (Bennett-Levy, 2005). For example, an experienced therapist who recently participated in an SP/SR course reflected: “I feel I have taken away so many important things,

but having experienced therapy has deepened my understanding of the importance of a good therapeutic alliance, collaboration, interest, trust, acceptance, compassion, etc.”

Bennett-Levy (2005) has argued that the enhanced interpersonal skills (e.g. perceptual, relational) infuse other more cognitive therapy-specific skills (e.g. the technical skills of setting up a behavioural experiment) with greater interpersonal sensitivity; the end result is greater “professional artistry” (Schön, 1983), or, in terms of the DPR model, more seamless when-then skills. The fact that SP/SR also impacts on two other major contributors to interpersonal skills, the self-schema (Bennett-Levy *et al.*, 2001) and self-reflection (Bennett-Levy *et al.*, 2003), further suggests its particular relevance to interpersonal skill training. Though the value of self-experiential and reflective strategies still awaits empirical verification using behavioural skill measures rather than self-report, a growing empirical base and an increasingly coherent theory of therapist skill development suggest that cognitive therapists need to seriously consider taking on board self-practice and self-reflection as frontline training strategies (Laireiter & Willutzki, 2005).

### **Role-playing**

Role-playing is the key way in training workshops to develop procedural skills without using personal material, which for a number of reasons is often not appropriate; for example, confidentiality, safety, type of issue or type of client group. It also became a prominent part of interpersonal skills training with the development of the microcounselling training model (Daniels, Rigazio-Digilio, & Ivey, 1997). There is a sound evidential base for its effectiveness (Alberts & Edelstein, 1990; Daniels *et al.*, 1997), especially when appropriate feedback is provided. For supervisors, role-playing provides a live opportunity to see strengths and limitations, and coach microskills.

Other strategies such as didactic learning or live or videotaped demonstrations may provide the conceptual background and guidance for procedural learning, but it is only by enacting the skills in practice that trainees can gauge what works and what does not, and where the gaps in their skills lie (Padesky, 1996). Furthermore, there is evidence that procedural skills are encoded and stored differently in memory from declarative learning, and require enactive strategies for effective learning (Engelkamp, 1998).

### **Other common training strategies: Didactic teaching and modelling/demonstrations**

It is our perception that the value of didactic teaching is frequently over-rated by cognitive therapy trainers. Trainers who spend the greater proportion of day-long workshops in lecture mode – we have seen many

examples of this – may be doing trainees a disservice if the purpose of training is the acquisition or refinement of procedural skills. Certainly, didactic learning is a useful method, but not the only one (others being, for example, reading, video demonstrations) for acquiring declarative knowledge (Padesky, 1996). As Binder (1999) has so cogently observed, there is a danger that declarative knowledge becomes “inert” unless practised.

Video or live demonstrations can be very helpful, especially with appropriate orientation and reflection questions (Padesky, 1996). We can, and should, ask trainees to focus their attention on specific elements of demonstrations according to need: content or process, verbal or nonverbal communication, therapist attitude, perceptual skills, relational skills, declarative theory – or even reflective skills. For instance, Safran and Muran (2000) suggest a strategy where supervisors model the reflective process by role-playing the therapist while “thinking aloud”, thus illustrating their internal reflections on their emotional state, thoughts and when–then rules.

At best, demonstrations can provide a powerful bridge between declarative knowledge and procedural skills. A colleague recently remarked that a video demonstration by a therapist calmly and effectively dealing with a very hostile client taught her more than hundreds of hours of reading could ever do. However, as microskills trainers have so effectively demonstrated, it is not enough just to tell and show (Alberts & Edelstein, 1990; Baker *et al.*, 1990). Practice, feedback and reflection are necessary to maximize acquisition of interpersonal skills.

### ***Use of videotape and audiotape in supervision***

We cannot rely on self-report if we want to assess interpersonal skills. Trainees may simply not notice problems because these skills are so intrinsic to the self-schema and automatized; or they may feel embarrassed about skills deficits, and unwilling to report them; or they may attribute difficulties to client factors rather than the relationship. Videotapes or audiotapes of trainees’ clinical sessions provide essential information unavailable by other means. Videotape has the advantage over audiotape of providing considerably more information about nonverbal interpersonal behaviours.

### ***Perceptual skills training***

We are specifically addressing perceptual skills training here because the understanding of interpersonal skills within cognitive therapy has lagged behind that of conceptual and technical skills, and cognitive therapists have rarely identified perceptual skills as a separate identifiable category. Writers from other psychotherapeutic traditions (e.g. Greenberg & Goldman, 1988) have highlighted their importance. Since the recognition of nonverbal signals and complex emotions is such an important feature of perceptual skill, we

would suggest the specific value of emotion recognition training (Machado *et al.*, 1999), and nonverbal skills sensitivity training (Grace, Kivlighan, & Kunce, 1995), especially for novice cognitive therapists without previous therapy experience.

An alternative method for using session tapes specifically to focus on perceptual skills has been described by Safran and Muran (2000). Here the supervisor stops the tape at key interpersonal points and asks the supervisee to reconstruct their reaction at the time. The aim of this strategy (similar to interpersonal process recall; Kagan & Kagan, 1997) is for supervisees to become more attuned to their internal processes by recalling thoughts, feelings and goals whenever they come to mind.

### **Deficits in reflection**

We have suggested that reflection, and in particular self-reflection, is central to the development and refinement of interpersonal skill, and have identified two kinds of reflection deficits: general and self-reflection deficits. We believe the identification of these two kinds of deficit to be important to the conceptualization of interpersonal skills problems. At this stage, while our suggestions for remediation in Table 12.1 are largely speculative, we have recent evidence from trainees' self-report that reflection worksheets promote procedural skills (Bennett-Levy & Padesky, submitted for publication).

### **Self-schema problems**

Figure 12.1 indicates that self-schema problems may directly impact on interpersonal skills. Ladany *et al.* (2005) suggest that three kinds of self-schema problem may affect therapeutic efficacy: self-confidence problems, emotional exhaustion or vicarious traumatization, and major characterological deficits. Clearly ways of addressing each vary considerably. In addition, of course, countertransference reactions resulting from self-schema emotional activation are central to interpersonal problems, as various chapters in this book (e.g. Leahy, Chapter 11; Newman, Chapter 8) have indicated. The six-stage process model has been suggested as an appropriate strategy here.

The traditional path for addressing self-schema problems has been personal therapy. Cognitive therapists apparently seek therapy less than other therapists (Orlinsky, Botermans, Rønnestad & the SPR Network, 2001). When they do, they tend to choose therapists from other therapy traditions. Full discussion of the value of personal therapy and therapy orientation is beyond the scope of the present chapter. However, we concur with Laireiter and Willutzki's (2005) suggestion that, early in their career, it makes sense for cognitive therapy trainees choosing a personal therapy path to experience cognitive therapy for themselves. Later, they may choose other orientations for personal reasons, and/or to broaden and enrich their style.

Mindfulness training has also been suggested as an appropriate strategy for the personal and professional development of therapists (Safran & Muran, 2000). Again, though data on its impact on therapists is lacking, the suggestion is certainly consistent with the need for therapists to develop mindfulness of inner states (Safran & Muran, 2000; Bennett-Levy, 2006). At a personal level, there is plenty of data to suggest that mindfulness also has beneficial effects on mental health.

Finally, both Mahoney (2000) and Skovholt (2001) have emphasized the importance of therapist self-care for both personal and professional reasons. Being a therapist is a demanding task; treating ourselves with the care and respect that we would want for our clients may be just as important for their health as for ours.

### **Concluding remarks**

It has been our aim in this chapter to present a model of therapist skill development that conceptualizes interpersonal skill problems in therapists within an information-processing context. The model identifies different types of interpersonal difficulty (for example, perceptual, relational), derived from different sources (for example, declarative knowledge problems, self-schema, general reflection deficit), and suggests a variety of developmental strategies for different contexts (training, supervision, self-supervision). We have emphasized that if we are to engage trainees to change their behaviours in this most sensitive of areas, supervisors and trainers must be particularly mindful of their own communications in the supervisory relationship.

Our analysis, derived from the DPR model, leads to the inescapable conclusion that interpersonal skills are intimately related to our personal (self-schema) development and capacity to reflect on our experience. We suggest that cognitive therapists should no longer avoid the implications of this conclusion. What does this mean for training? How can we incorporate and balance personal and professional development within our courses? What kind of personal development is most appropriate? Clearly there are many questions to be addressed, and considerable need for research. We believe that we are now at the point where there is sufficient empirical and theoretical rationale to canvass these issues. Enough of avoidance! Time for cognitive therapy to engage in this kind of reflection on itself.

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