

Chapter 20

When therapists have problems: what can CBT do for us?

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In our training and work, we frequently see how helpful CBT can be for others. At times we may have used the methods on ourselves to look at personal issues or issues which have emerged within our relationships with patients. Sometimes we may find we need more support than can be provided by family and friends. We may want to be more structured in our use of CBT for ourselves, or may want to seek therapy. When the going gets tough, can we turn to CBT for help? In this chapter, we look at how we can use a brief, focused form of CBT to help in our professional and personal development, how to use CBT on ourselves, and whether being CBT therapists is valuable for us as individuals.

Introduction

Early in your cognitive behavioural therapy (CBT) career you will, hopefully, have come across many examples of ways in which CBT can make a difference. You will also be getting a good idea of the limitations of the approach, people whom CBT does and does not suit, and times and situations where the methods are or are not applicable. No doubt the philosophy and method has got under your skin, and maybe you use it in various ways both in your professional life and in your personal life, finding that the methods and approach are as applicable to you as to your patients.

It is only recently in the history of CBT that the role of the therapist has been looked at in any depth (Gilbert and Leahy, 2007). Cognitive models were originally developed for people with relatively short-term focused problems, with the assumption that the therapist is providing at the very least the core conditions of the relationship, and therefore the contribution of the therapist to the relationship was not viewed as of particular importance. In other forms of psychotherapy such as person-centred and psychodynamic, the relationship is centre stage, and the therapist's issues and process are seen as a central part of the dynamics of change. These differing philosophies are reflected in training requirements. Personal therapy is perceived to be an important, if not essential, requirement for counsellors and psychotherapists (Norcross, 2005; Wilkins, 2006), and therapists rate their time in therapy as an important aspect of their overall clinical development (Macran and Shapiro, 1998; Orlinsky *et al.*, 2001). A minimum of 40 hours of personal therapy is a mandatory requirement for professional membership of the BPS Division of Counselling Psychology, the British Association for Counselling and Psychotherapy (BACP), and the United Kingdom Council for Psychotherapy (UKCP). In countries such as Sweden and Switzerland, CBT therapists need to be registered as psychotherapists in order to practice, and personal therapy is a mandatory requirement for psychotherapy registration.

In the world of cognitive and behavioural therapies, in contrast, personal therapy is not currently seen as an essential, or widely accepted, aspect of training or as necessary for accreditation (EABCT, 2000). The British Association for Behavioural and Cognitive Psychotherapies (BABCP) stipulate, 'Therapists must ensure that they can identify and manage appropriately their personal involvement in the process of cognitive and/or behaviour therapy' and 'Therapists must have developed an ability to recognize when they should seek other professional advice' (BABCP, 2000), and personal therapy is not stipulated as a training requirement within the UK Division of Clinical Psychology. An assumption appears to arise: are we CBT therapists completely well-balanced, sorted people who are able to work with the complexities and sensitivities of other people without being affected by, or affecting, the experience? Are all other therapy schools more suitable to therapists who are themselves in need of personal help? Is the well-being or otherwise of therapists and engagement in personal therapy not relevant to the process of CBT?

Jacqueline Persons (1989) was one of the first to mention the ways in which CBT might be useful for therapists, mainly in the context of improving our therapeutic skills rather than general lives. Many of the key names in cognitive therapy have stressed the importance of trying CBT out for ourselves. 'To fully understand the process of therapy, there is no substitute for using cognitive

therapy methods on oneself, wrote Christine Padesky (1996, p. 288). Judith Beck (1995, p. 312) stated, 'to gain experience with basic techniques of cognitive therapy by practicing them on yourself before doing so with patients... and putting yourself in the patient's role affords the opportunity to identify obstacles that interfere with carrying out assignments'.

While such work addresses the issue of using CBT on ourselves to improve our effectiveness as therapists, do we also gain personally as a result of being therapists? Are the methods and approaches useful to us in life in general? Are we better prepared to get through the stresses and difficulties, and hellish times that life can offer?

In this chapter, we consider two central questions about ourselves as therapists. Does personal experience of CBT enhance our understanding and skills as therapists? And second, can we use our training and clinical experience to help us get through the various painful difficulties that can arise in our lives, both from external events and our own issues? The chapter is divided into three sections. In the first section, James Bennett-Levy considers the ways in which personal experience of CBT is used in training, focusing on his work on self-practice/self-reflection (SP/SR). In the second section, Diana Sanders looks at ways in which being a therapist can both help and hinder how we cope with life's difficulties, with illustrations from her own experience of physical illness and disability. In the third section, 'Jess', a CBT therapist, discusses her experience of receiving long-term CBT. She reflects on her struggles as a patient, and the valuable lessons that she learned about being a therapist.

Experiencing CBT for ourselves: the value of self-practice/self-reflection

In 1988, I (James) undertook a 6-month CBT training course at the Institute of Psychiatry, London, the first such training course in the United Kingdom (Moorey *et al.*, 1990). About half way through the course, one of the other trainees 'Susan' and I agreed that we wanted to try out the methods on ourselves. Therefore, we contracted to do four sessions with each other, focusing on a circumscribed problem. Each meeting lasted about 2½ hours: 50-minute sessions each, plus reflection time. At the end of each therapy session, Susan and I reflected on our experience as therapist and client, had a tea break, and then swapped roles. In the following week, we wrote up our reflections and shared any new thoughts at the start of the following session.

At the end of our time together, we both agreed that our work had provided another dimension on being a cognitive therapist. We had integrated our new understandings, and translated them into clinical skills rather better than by

simply relying on our learning from clinical experience and supervision, valuable though the latter was. In the client's chair, we had particularly valued the 'non-specific' elements of therapy—the care, empathy, and interest of the other—as well as the opportunity to experience and practice CBT-specific skills. There was no doubt that the sessions had personal value for us as people (not just as therapists), helping us to deal better with the issues on which we had focused in 'therapy'. Those four sessions proved to be, effectively, our first experience of SP/SR in CBT.

SP/SR—developing the model

Ten years later, when teaching my first CBT training program on the clinical psychology course at James Cook University in North Queensland, Australia, and remembering our happy and useful self-therapy experiences, I included a 'personal experiential component' in the course syllabus. Naively in retrospect, I imagined that this innovation would be greeted with enthusiasm by eager-to-experiment trainees. How wrong could I be!

Fortunately, I had the sense to call a meeting before the course started to discuss the experiential component and agree a format and set of procedures. In the words of one trainee, Tina:

When I first read that thing about having a reflection assignment, I thought, "Oh god! How stupid!" I was really appalled. It got me offside from the start. It was shocking... It was like, when I'd bump into people who were doing the course, I'd say, "did you read that thing... it's scary isn't it!"

By the end of the 12-week course, Tina's view had changed radically:

I think knowing how to do it for yourself covers all the bases. If you know how to do it... then you can pass that knowledge on to other people. Because you understand it for yourself, rather than having understood it from a book or something. You can then also problem-solve with somebody who does have difficulties with that ... put it in your words and explain it to a person, rather than take it from a book and try to explain it from a technical perspective.

Setting up an SP/SR group

To date, SP/SR groups have been established either in the context of university degree programs (clinical psychology or CBT), or stand-alone professional development courses. However, there is no reason why individuals or pairs may not undertake SP/SR on their own, as Susan and I did. The basic structure is straightforward: the self-practice (SP) part involves trainees practicing CBT techniques on each other, the self-reflection (SR) component has them reflecting on their experience.

We have developed two SP forms: solo and pairs. The 'solo' form of SP (Bennett-Levy *et al.*, 2001) allows trainees to practice CBT techniques on

themselves via a purpose-designed SP/SR workbook, which contains weekly structured exercises (e.g. do an activity schedule, thought record, etc.). The second type of SP is a ‘co-therapy’ form where trainees pair up and offer each other therapy for a few sessions, swapping half way so both have time as ‘client’ and ‘therapist’. Co-therapists are encouraged to focus on a mild-to-moderate, rather than severe, problem, as Susan and I had done during our training (Bennett-Levy *et al.*, 2003).

A key feature of SP/SR is the reflective (SR) component (Bennett-Levy *et al.*, 2009). After both forms of SP, participants write up their session reflections (SR) during the following week. These are collated by the facilitator and emailed—anonymously to preserve confidentiality—to the rest of the group. Participants are encouraged to reflect on their personal experience of CBT techniques, and on its implications for their clinical practice and understanding of cognitive theory. Sharing group reflections provides a rounded context for personal experience; it enables participants to see what kinds of experience may be common to others, and what may be relatively idiosyncratic responses.

SP/SR for personal gains

The rationale for SP/SR has always been founded on its value as a method for developing and enhancing therapist skills (Bennett-Levy *et al.*, 2001). However, of particular relevance for the present chapter is that a significant percentage of people report *personal* as well as professional gains. Interestingly, experienced therapists typically report just as much benefit from SP/SR as novices (Bennett-Levy *et al.*, 2009) and sometimes the changes are dramatic. Jeff, doing a workbook version of SP/SR for experienced therapists, wrote:

This whole experience has had so many positive effects, too numerous to detail, but most importantly, what I am now doing is treating myself with compassion—and I really am! I’m managing to sustain it, and of course it is influencing my therapy. I believe that I have pretty much always displayed compassion as a therapist, but there has been a shift within me that has moved it onto a different level.

Although not everyone who does SP/SR experiences personal and professional shifts of the intensity Jeff describes, almost all trainees report that it impacts on their skills and understanding of CBT (Bennett-Levy *et al.*, 2001). We have also gathered quantitative data which provides harder evidence that practicing CBT on oneself can have personal, as well as professional benefits (Davis *et al.*, 2008). Davis *et al.* (2008) reported that highly experienced SP/SR participants demonstrated significant changes in personal and therapist beliefs, as well as measurable gains in self-reported CBT skills and empathy (Bennett-Levy *et al.*, 2009). Participants were asked at the start of the course to identify one personal belief (e.g. ‘I’m a failure’) and one therapist belief (e.g. ‘I’m an incompetent therapist’) that they would like to change. They then used CBT

techniques such as positive data logs and behavioural experiments to modify and test out these beliefs. The results showed significant changes in beliefs over the duration of the course for all participants.

The data that have been gathered in the United Kingdom and Australia is supported by a parallel set of studies from Germany, summarized by Laireiter and Willutzki (2003). All these studies suggest that practicing CBT on oneself, either with the support of a ‘co-therapist’ or on one’s own can be valuable both professionally and personally. CBT therapists do not have to have identifiable disorders in order to gain from CBT methods, though like many others, they may also benefit from CBT if they do.

SP/SR: limitations and warnings

During 10 years of research, we have been consistently impressed by the power of SP/SR. Although usually positive, the experience of the client role occasionally causes unexpected levels of emotional distress, at least in the short term. We therefore have several caveats to working effectively with SP/SR.

There is huge variability in the extent to which CBT therapists are willing to engage in personal experiential work and self-reflection. A consistent finding from studies with different groups of novice or experienced therapists is that participants differ considerably in their level of engagement—and degree of engagement with the process of SP/SR is highly correlated with the experience of benefit (Bennett-Levy *et al.*, 2001). Engagement is a function of a variety of factors, the most important of which for the present context are available personal resources and feeling of safety with the process.

Personal resources for SP/SR

SP/SR takes emotional energy and participants need to have time in which to reflect on their experience. We suggest setting aside at least 2 hours a week to do SP/SR. It is one of the ironies of life, both for therapists and clients, that the conditions which best promote reflection—having time, space, and personal resources—are often those most compromised by stressful life events or circumstances. Therefore, we advise prospective participants not to do SP/SR programs at times of high stress or intense work. Even then, ‘life’ can catch up with people during 10-week programs, and, as in all therapy, some people do dropout (Davis *et al.*, 2008).

Safe practice of SP/SR

Promoting safety within the process is essential. A prerequisite for all SP/SR courses is a clear agreement around boundaries and confidentiality. Typical agreements will include the following:

- ◆ All participants’ email reflections are circulated anonymously.

- ◆ Make clear distinctions between content and process—focus reflections on the *process* of interventions, rather than the personal *content*.
- ◆ If you are working in pairs, personal issues discussed stay within the pair unless the person concerned specifically gives his/her permission for it to be discussed in the group.

With groups of professional colleagues working in the same region, our experience is that it is far preferable to go the ‘solo workbook’ route (rather than pairs), otherwise safety and boundary issues raise their heads. In ‘limited co-therapy’ SP/SR groups, we always recommend participants to work with people they do not know, even if they already have close confiding friendship with another participant. Prior knowledge of and relationship with another does not mimic therapy and introduces its own complications.

Pandora’s box

Some CBT therapists, both novice and experienced, are concerned that if they ‘dig’, they might unleash something that they are unable to control or deal with in brief SP/SR, and for some this concern is well-grounded. An example is provided by Terry who was doing a responsibility pie chart:

I revisited an event from some 16 years ago. I faithfully allocated slices of responsibility ... This was when things started to go wrong. I started to feel increasingly depressed about the situation and reassigning slices of responsibility to various contributors only made things worse ... Suddenly, I felt even more guilt and shame about my attempts to reconstruct an experience for which I previously took full responsibility. I found myself re-living the whole situation over and over again. Each episode resulted in an increased number of NATs which in turn compelled me to dwell on the events even more ... I was so preoccupied with the emotional roller coaster, that I found myself unable to do any meaningful work.

Although deeply uncomfortable for a couple of weeks, Terry reflected at the end of the course that this had been a pivotal experience which would have a lasting effect on his clinical work.

For me personally, it was a chance of self-discovery which unearthed some amazing facets about the way I deal with my problems as well as a true test of the cognitive-behaviour methods of intervention.

Since that time, we have always insisted that trainees undertaking SP/SR have a ‘personal safeguard strategy’ in place. We have recommended three levels of safeguards:

- 1 Discuss your distress or difficulties with another identified member of the group (e.g. co-therapist) if it feels safe to do so.
- 2 Discuss difficulties with the group facilitator.
- 3 If the above does not resolve things, seek outside help with a therapist.

In some groups, the SP/SR facilitators have already identified therapists who are prepared to offer their services in the event of significant distress; in others we have asked participants to identify a therapist who they would go to as a condition of acceptance into the program. To our knowledge, only 1 or 2 participants have ever required this kind of outside help.

The strategy above relies to some extent on our ability to make judgements about how our responses and difficulties can be best resolved, and whether we do need personal therapy or outside help. Ironically, we are often least able to make such judgements when we are very low stressed or burnt out ('I should be able to handle this ...'). Depression, anxiety, or other 'diagnosable' problems are easier to spot in others than in ourselves. Use of formal measures such as the Beck Depression Inventory II (Beck et al., 1996) or Maslach Burnout Inventory (Schutte et al., 2000) can often be of value in determining level of support needed. High scores might indicate it is time to seek external assistance.

SP/SR: recommendations

To date, SP/SR has only been researched in groups in specific training contexts. We do not know to what extent the results would generalize to, for instance, colleagues setting up an informal SP/SR pairing, as Susan and I did. However, within the parameters of the research to date, we can recommend the following:

- 1 The vast majority of participants find SP/SR very helpful for their development as therapists (and/or supervisors) and a significant proportion find it helpful in their personal development.
- 2 Information and choice are central to success of SP/SR. This includes clear information about expectations (time, commitment, emotional resources, potential benefits); pros and cons of different SP/SR methods (e.g. limited co-therapy or workbook); choice of partners (do not work with colleagues or friends); and well-negotiated agreements around safety and confidentiality.
- 3 Reflection and evaluation are as important in SP/SR as the experiential work. Our experience suggests that written reflections add enormous value, enabling participants to conceptualize and integrate personal experience with professional understanding and clinical skills.
- 4 A small proportion of participants experience unexpected distress during SP/SR programs. Each participant should have a personal safeguard strategy in place prior to commencement of a program.

Does it help, being a therapist?

I (Diana) was asked the question at 2 in the morning in June 2002. I had just come out of intensive care following a heart and lung transplant, and couldn't get to sleep. My chest was held together with wires, four large drains came out of my abdomen, tubes from my neck and both arms, and I was hallucinating and nauseous from morphine and a cocktail of other medication. I was crying and wanted to go home. It was not the best time for a question about work.

It was a question I revisited several times in my recovery from the operation. Was CBT helpful, or did it in fact get in the way, giving me and my carers expectations that I should be able to cope, given my training? A visit to the website and journal of the BACP gives many examples of therapists writing about their personal experience and how these impact on themselves as people as well as therapists (www.bacp.org.uk). However, there is far less within the CBT literature. For me, although my training and experience of CBT was in some ways enormously helpful, giving me methods such as goal setting, activity scheduling, and reducing negative thinking, to cope with a long period of illness and waiting for a transplant, at other times it felt like a hindrance (Sanders, 2006; Sanders, 2008). For example, I found it very tough to both recognize, and admit, that I had become depressed after the surgery. Although I had worked with many clients with depression, it was extremely difficult to detect and accept the problem in myself. On some level, perhaps not always consciously, I expected to be able to cope better than I felt I did. The expectations came not just from me—medical staff would sometimes treat me differently from other patients, perhaps with the assumption that I would need less psychological support since I could do it myself. Beck and Butler (2005), in a chapter on treating psychotherapists with cognitive therapy made a similar observation, that a high percentage of therapists come to therapy with ideas like 'I shouldn't have these problems' and 'I should be able to handle my problems without help'.

It is possible that many of us in the caring professions find it hard to spot when things are too much, when low mood tips into clinical depression. In a survey of 1,000 therapists (Gilroy *et al.*, 2002), those who had experienced depression reported that their emotional issues gave them more empathy for their clients; however, they also experienced an increased sense of isolation from their colleagues and difficulties in discussing their personal experience.

The issue of whether being CBT therapists is helpful to us, personally, raises important questions which we consider below: do we chose to work in the area of psychology and psychotherapy because of our personal histories and experience

of mental health difficulties? How can we use CBT methods on ourselves to help with issues that come up during therapy; and what to do when we, as therapists, need professional help?

Choosing therapy as a profession

Is psychotherapy a profession we choose because of our own experience of mental health issues? Choosing a career is a complex decision, and personal experience of problems may be only part of the reason: however, it makes sense for us to choose a career path which we find personally engaging, for whatever reasons. To our knowledge, there is no study looking specifically at CBT psychotherapists. In one small study, Fussell and Bonney (1990) compared the childhood experiences of 42 psychotherapists and 38 physicists. The psychotherapists reported a comparatively high incidence of childhood trauma and emotional deprivation, suggesting that they were aware of the potential negative impact of the past on their present lives. They felt that their difficulties enhanced, instead of extinguished, their continuing interest in people. It makes sense that our personal experience can help us to understand those with similar backgrounds, and in certain professions may be an almost essential requirement. It is probably the case that some experience of emotional upset, which comes with the simple fact of being human, is an essential requirement for being an effective therapist. But with regard to the question of whether lifelong struggles with mental health issues are essential, or indeed make for good therapists, opinion may be divided. In my own experience, I have a particular interest in working with the cardiac rehabilitation service. I find that I can certainly empathize with my patient's experience of various medical tests and investigations, side effects of medication, and recovery from surgery—but I always have to be wary of comparing my patient's experience to my own, and listen to their stories with no bias from my own. We need to be aware of our own issues and their impact on therapy through careful use of regular supervision, as illustrated below.

When our personal lives affect therapy

Although our patients may like to think of us as towers of granite, unfailingly there for them with unwavering attention, leaving all our 'baggage' on our doorsteps, in reality we are all too human and life takes its toll, as the following personal example illustrates.

When my father died, I took two weeks off before returning to work. When I returned, my first patient of the day, Angela, knew why I had taken leave and offered me her condolences. The session then focused on her difficulties coping with her elderly father who had terminal cancer. I was aware as she spoke of my own feelings coming to the surface, which made me want to steer the session away from the emotion in case I started crying. Angela, being a warm and sympathetic

person, was all too aware of what was going on. Half-way through the session, she stopped, looked aghast at me and said “Listen to me going on about my father. At least I still have him, unlike you. I am so sorry, I’ve been so selfish”.

In this case, it was clear that my own grief around losing my father meant that it almost became unclear who was the patient, and we potentially swapped roles. I was also unclear about how to deal with my own distress. I felt a moment of panic—I am going to start crying. I mustn’t cry—and a dilemma about which direction to go in: should I stop the session and say that I am not able to continue? In fact, I pushed down my own feelings, told Angela that the therapy time was for her, not for me, and that she could say whatever she liked to me. She changed the subject and talked instead about her young grand-daughter. We seemed to get back on track, somehow. After the session, I locked myself in the loo and howled.

These moments affect all of us at some stage, and mean that at times of difficulty in our own lives, we need to ask ourselves whether we are sufficiently OK to be working. Sometimes we do not know until a situation such as above arises. In my case, I thought that I was more OK than I actually was, that I could simply put my own feelings on the back burner, which in retrospect was a mistake. It would, perhaps, have been better to stay away from clinical work for a little longer, which is, however, not always possible within a busy NHS (National Health Service) setting. I realize that my patient, Angela, would be fine and understanding if I cancelled sessions; however, other patients find cancellations much more difficult. I also recognized that I needed more time to grieve, and was able to share a very informal SP/SR arrangement with a friend and colleague who had also lost her father recently. We also need to be aware of our own beliefs which impact on how we look after ourselves: for example, ‘I should be OK’, ‘I’m a therapist, I can cope with this’ and ‘My personal feelings and reactions can be neatly tidied away when necessary’ may get in the way of us taking time out when we need it.

When personal beliefs affect treatment

In addition to what is going on in our lives, our own beliefs impact on therapy, and may cause not only one-off but recurrent problems in our therapeutic style or process (Haarhoff, 2006; Persons, 1989; Sanders and Wills, 2006). One study has identified how therapists’ beliefs about homework, such as ‘it makes me feel like a teacher’ and ‘I don’t like to put pressure on my patients’, may cause homework-setting to be rushed or trivialized (Haarhoff and Kazantzis, 2007). Core beliefs about being a caring person, whereas others are needy and vulnerable, may lead us to focus on empathy and allowing the client to talk uninterruptedly, not allowing time for collaboratively worked on interventions. Other beliefs which might affect us include: ‘It is wrong to dislike/disagree with/feel attracted

to/be angry with my patients'; 'I must cure everyone I see, otherwise I'm a useless therapist'; or 'I'm totally responsible for whether or not my therapy is successful' (Gilbert and Leahy, 2007; Sanders and Wills, 2006). Such rules are likely to interfere with the therapeutic relationship: if you have particular feelings or thoughts that contravene your rules, then they may be ignored or put back on to the patient, rather than be actively used in therapy (Haarhoff, 2006). If, for example, you are feeling annoyed with a patient, which is not an uncommon reaction, but you also believe that you must never show or share this annoyance, you may be more likely to think 'So and so is being irritating: it is his fault: I won't let it affect me', rather than stopping and thinking what exactly is going on to arouse these feelings of annoyance in you—and therefore gain potentially valuable insights. Sometimes our annoyance, anger, or attraction is reflecting whatever is going on for the patient, and needs examining.

A rule of thumb is to first be able to spot when our own beliefs may be getting in the way, and second, find a potential solution. Spotting difficulties can be enormously helped by taking a compassionate and reflective view of our own work. Using thought records and therapy tapes, we can ask ourselves questions such as:

- ◆ How did that go?
- ◆ Was there a problem?
- ◆ How did the patient make me feel?
- ◆ What goes through my mind when I think about the patient?
- ◆ Are there 'oughts', 'shoulds', or 'musts'?
- ◆ What is making it difficult to really understand and empathize with this person?
- ◆ Am I making assumptions?
- ◆ What does the patient need right now?
- ◆ What do I need?

Sometimes finding an image of the patient can be helpful in pointing toward our own feelings: seeing our patients as ever-hungry babies or seeing yourself as a wise owl or a helpful teacher may indicate that we are feeling the need to cure, or teach, or take care of the patients, to a degree which risks losing collaboration. Feeling dragged down into the mud at the thought of seeing our patients means that we may be feeling stuck due to chronic avoidance, by ourselves or the patients. Negative feelings in general toward our patients are useful pointers to issues going on in the therapeutic relationship, and we cannot

automatically assume they arise from the patient, but may be pointers that we need to focus on ourselves.

We cannot stress too much the importance of taking supervision in these situations. Self-reflection can take us a certain distance, but our interpersonal styles may have become so ingrained over many years that we may simply not notice what is obvious to the external observer (Bennett-Levy and Thwaites, 2007). Various CBT resources are now available to help therapists work with their beliefs and assumptions (Bennett-Levy and Thwaites, 2007; Davis *et al.*, 2008; Gilbert and Leahy, 2007; Haarhof, 2006). The key is to tackle problems at an early stage and to be prepared to look at the process of the relationship when necessary. This does not mean that the relationship itself needs to be the focus of the therapy, but realizing that, even in short-term focused work, relationship issues can become a problem needing attention.

However good a therapist we are, however compassionate, it is likely that at times unhelpful thoughts and beliefs will be activated. We are after all humans interacting in a human situation, so our own views and experiences are bound to impinge on the relationship. All in all, we feel that we should, as Lao-Tzu advises, in the *Tao te ching* (Lao-Tzu, 1963) yield to our own fallibility in order to overcome the problems of therapist perfectionism. We should be ready to admit our mistakes, a gesture often appreciated by clients frequently burdened by a sense of their own fallibility.

When we need therapy ourselves

What do we as CBT therapists do when problems in our personal lives become too difficult to tackle on our own, and we need professional help? How do we spot such problems? From our earlier examples, the latter is probably the more difficult: knowing and admitting that we need help. Often it is our close friends and relatives who can identify problems before we are aware of them, and taking their advice is often far more important than listening to our own, inevitably biased, judgements. Knowing our own distress signatures is important: for example, the more stressed I get, the more work I take on, and the more unrealistic my expectations of myself, a condition well-recognized by my husband long before the penny drops for me. I personally feel that colleagues working in a mental health setting have an ethical responsibility to keep an eye open for other colleague's well-being, which may mean a difficult discussion about what he or she needs.

Once we make the decision to undergo formal therapy, we face the same question that our clients ask: what type of therapist and form of therapy is going to be right for me at this time for this particular issue (Wilkins, 2006)?

Where do I find a suitable therapist? Should I choose another CBT therapist or go for another model?

Therapists seek therapy for three main reasons: personal growth, personal problems, and personal training, with personal growth being the most commonly cited reason for undertaking therapy (Orlinsky *et al.*, 2005). Being able to identify what we are looking for helps us choose where to go: is it for specific problems, such as anxiety, panic, or depression, or are we identifying chronic difficulties, suggesting schema issues? Is the problem within our relationship at home, and do we need relationship therapy? As for assessing the needs of our patients, assessing our own can be vital, either alone or within SP/SR arrangement.

Should CBT therapists choose CBT therapists for therapy, or therapists from different orientations? Interestingly, CBT therapists seeking therapy tend to choose orientations other than CBT (Orlinsky *et al.*, 2001). Although choosing a therapist of the same orientation can be affirming and informative, Christine Padesky (1996) stresses the value of using another CBT therapist: 'It is helpful for cognitive therapists to seek cognitive therapy when in need of psychotherapy. Cognitive therapy initiated during a crisis can be extended to include identification and exploration of schema issues that may maintain problem patterns' (p. 288). She goes on to state, however, that it can be difficult to find another local therapist who is not also a colleague or friend (Padesky, 1996). Another potential problem is that being familiar with our therapist's model may mean we are overly aware of technique and therefore miss opportunities to look at things differently: 'I know what you are going to ask me next', or 'why hasn't she asked me the right questions' may get in the way of us being able to 'relax' into the role of patient.

Choosing a therapist working with a different model, such as person-centred or psychodynamic, has disadvantages as well as advantages. Our commitment to a particular model such as CBT may be a matter of deeply held beliefs, and we may find it difficult to experience therapy coming from different approaches. For example, if you feel strongly that the collaborative and open nature of CBT is an empowering and essential way of working, psychoanalytic traditions may be uncomfortable—which is not to say that a different approach is not valuable. If you know that your problems fall into categories where the evidence falls in favour of CBT over other models, such as depression, then CBT may be your therapy of choice. If, however, you mainly want a chance to talk over difficulties, and find solutions yourself, a person-centred approach might be appropriate.

When looking for a personal therapist, we should consider our purpose: personal growth, personal problems, or personal training. We should consider the

fit between our worldview and that of the therapist. We should also take into account the data suggesting that alliance accounts for more of the variance in outcome than technique (Hubble *et al.*, 1999), a finding apparently mirrored in the CBT literature (Trepka *et al.*, 2004). Therefore, perhaps we should be guided by the advice we would give our own patients, or when hiring a builder or plumber: get recommendations, find out the background and professional qualifications of the therapist, and make sure your therapist can do the job you want, and is someone with whom you feel comfortable and can trust.

The last section of this chapter features an in-depth report of a mental health professional's experience of receiving long-term CBT. We learn from the inside how and why the patient, Jess, experiences CBT as so valuable. In particular, she highlights both the importance of the therapeutic relationship—frequently illustrated with comments about empathy, genuineness, trust, curiosity, validation, and interest. And she also notes how effective CBT formulation and specific techniques can be. If as readers we can imbibe Jess' story, we too can gain quite a different and unique understanding about the process of therapy.

Jess: Physicians can't always heal themselves: a health professional's account of receiving CBT for multiple problems

I am a 38-year-old mental health professional. I was referred for CBT by my general practitioner (GP), having spent my adult life trying to overcome a number of difficulties on my own, and using knowledge gained from my professional training. These difficulties included anorexia and bulimia, panic attacks, low mood, obsessional thoughts, and perfectionist beliefs. At the core of these difficulties were low self-esteem, and being cut off from, and frightened of, emotions.

Somewhat ironically then, I went to the first CBT assessment appointment thinking I didn't have sufficient problems to 'deserve' help. I was *convinced* that the psychologist who saw me would conclude the same and 'reject' me straight away. I was shocked and horrified when I was accepted for therapy, concluding that I must have misled my therapist into thinking I was worthy of any help. This experience activated a whole set of beliefs and interpersonal difficulties that were to underlie, if not dominate, my experience of therapy. After that first assessment session I became unable to think about anything else other than 'having misled the therapist'. I couldn't eat, sleep, work, or engage with my family and friends.

This reaction to assessment and being offered therapy really surprised me. It has made me more aware of how the assessment process may activate core

beliefs for people and that waiting for therapy, particularly having already been assessed, can be very difficult. Clients usually have to manage these difficulties without any interim therapeutic support. Fortunately, when it became clear how I had reacted to assessment, I was offered three scheduled telephone contacts to help me 'keep going' until therapy started. However, by the time therapy started (only a couple of months later) my mental health had deteriorated, and the first 18 months or so of CBT were extremely hard. Although I was 100% committed to therapy, engagement in it and forming a trusting therapeutic relationship were major problems that had to be addressed in order for me to make progress.

Engagement, early therapy, and the interpersonal relationship

At the outset I had a lot of thoughts that actively interfered with each therapy session. Firstly, dependency on anyone else was anathema. It took me some time to find a position of semi-dependence on my therapist which was needed to work effectively in therapy. Also, beliefs about my appearance ('I'm so repulsive') and my social skills ('I'm boring and thick') meant that I hated being seen by people and hated having to talk to people, both clearly problematic in a therapeutic relationship. I was, without doubt, the worst person imaginable; therefore everything I said in therapy was not to be trusted. I didn't deserve any therapy time and I certainly did not deserve to make any sort of recovery. Crucially, I fully expected abandonment, disgust, and criticism from the therapist.

Therefore, absolutely fundamental to my experience of therapy has been establishing a good therapeutic relationship. Without this, no manner of well-executed CBT techniques would have had any effect. To my surprise it took me almost two years to trust my therapist. It took a lot of misunderstandings and several therapeutic ruptures to reach a position where I genuinely realized that this person was reliable, dependable, and consistent. He was not going to suddenly disappear or abandon me. He was trying his best to help me, even though I found it very painful. He persisted with trying to help me even though I was certain about my beliefs.

I now think it's important, as a therapist, to have a reasonably robust sense of self and a relative ease with being alive. I learnt to feel safe in the room because my therapist conveyed a sense of solidity, that is, 'I'm OK, I can handle this, I am calm'. It also meant that we could work through therapy misunderstandings without fear that this would taint the rest of therapy. I reflect back on therapy I have given and wonder how different it would have been had I been both clearer about, and happier with, who I was.

Throughout therapy I have been extremely oversensitive to interpersonal cues and construed meanings from my therapist's behaviour. So, for example, if my therapist was one minute late, according to the waiting room clock, it meant he was really dreading seeing me. I would scrutinize his expression and tone of

voice when he greeted me in the waiting room to try and ascertain his state of mind. I was highly sensitive to small changes in my therapist's mood and made catastrophic interpretations about these (e.g. therapist is a fraction less cheerful than usual, therefore he's depressed, therefore he'll go off sick from work and abandon me). Having my homework handed back to me 'meant' I was being rejected/it was too boring to keep. The only day my therapist was ill I was convinced he was going to die and I waited to be contacted with news of his death. It sounds irrational with hindsight but it was very real to me, and repeatedly intruded on the therapy process. Attendance to these sensitivities using a cognitive behavioural framework provided a very rich source for learning in therapy.

Some of my intratherapy behaviour would have been difficult for me to deal with, particularly as a novice therapist. For example, when any emotional subject matter was touched on, particularly relating to sadness, I would grin broadly and laugh inappropriately. Such incongruence of affect could easily disconcert or trigger judgements in the mind of the therapist. This was, however, my way of coping with uncomfortable feelings, given that I had no way of escaping them in the session, and served as a way of dismissing anything emotional. It was certainly a response learnt through my upbringing. My therapist was probably rather startled by this but he took the time to understand what it was about and linked it into our formulation. I also learnt from this that if, as therapist, one is feeling frustrated or bewildered by a client's unusual behaviour in a session, bear in mind that your client is employing the best coping strategy he/she can in that moment of time. The client may be acutely aware of his/her behaviour and be highly critical of himself/herself for it too.

I was struck by how gruelling and exhausting therapy was. I absolutely dreaded attending! Waiting in the waiting room with other people, all of whom I was sure were much more 'deserving' than me made me feel really ashamed. Sitting in the therapy room, feeling bombarded with feelings I could neither work out, nor escape, was really stressful. I always felt extremely tired and raw after therapy, particularly for the first 18 months or so. I quickly learnt that having any engagement immediately after therapy was a bad idea. I found that I needed a couple of hours to recover from each session and start to reflect, though it would usually take some days to truly be able to think a bit more objectively. My partner learnt to steer clear of me after therapy sessions as I was much more irritable, preoccupied, and withdrawn.

Having this experience made me realize that I have practiced with the belief that therapy should be a comfortable, almost enjoyable experience for the recipient. However, I have come to realize this is not how it has to be to be effective. For me, therapy was a physically painful experience, probably because of my specific difficulties with emotions. There were numerous times when, if it wasn't for my own professional background, and my ultimate trust in my

therapist, I'd have cancelled or even dropped out of therapy. I am more sensitive to this with my own clients now and at the end of a difficult session, I try to troubleshoot any difficulties which may lead to future non-attendance.

CBT-specific reflections

Reflecting on specific CBT skills and techniques that I experienced, several are particularly memorable. Setting an agenda every session was always important. I have often felt uncomfortable using this exact term with my own clients, thinking it sounds too business-like and uncaring. However, therapy without an agenda would have been unhelpful and unproductive. I found that agenda-setting reduced my anxiety about sitting in the sessions as I wasn't on edge all session wondering what the therapist was going to bring up. It fostered a true sense of collaboration and transparency.

Socratic questioning is clearly a fundamental part of CBT. What was especially valuable about this for me was that my therapist was not making assumptions. He probably had some pretty good ideas of the answers to some of his questions but to appear genuinely curious allowed me to clarify some details and, particularly importantly, helped me to feel understood.

Having the therapist point out that, while I might tend to see the world in black and white terms, it didn't mean that *he* did, was really valuable. I can remember my therapist saying 'Yes, that could be true, but so could...'; 'That's possible but is it really likely or not?' I really didn't like this as I wanted '*certainty*' and not to talk in probabilities. I thought 'This middle ground is so unrealistic!' However, with repetition it became more tolerable as a concept. My therapist also highlighted that I *start off* from a position (a core belief) rather than *conclude it* on the basis of evidence. I was similarly very doubtful about this, but with time this too made sense.

In the session, I noticed that strong emotion, shame in particular, made it extremely difficult to think about my thoughts. Often, when talking about core issues, I couldn't think at all. I can best describe it as hearing the words, recognizing that they were in English, but being completely unable to translate them into anything that made any sense. At times like this I found diagrams helpful; having something written down on a whiteboard helped me focus and helped my understanding.

The educational component of therapy was one of the things that I valued the most. Lots of questions cropped up that I simply couldn't answer. For example, 'What sort of positive feelings are there?'; 'How do you distinguish between different types?' Here, judicious use of self-disclosure was extremely helpful. This wasn't about the therapist disclosing anything really personal, he simply modeled some normal thoughts, feelings, and behaviours. I'd have found a glib 'Well, what do you think?' very unhelpful as I just hadn't a clue and I lacked the knowledge to enable me to develop a view.

I really liked having homework! It helped me feel like I was doing everything I could between sessions to help myself. It also helped me feel less alone with the difficulties I was struggling with. There were often things I couldn't comprehend at all in therapy that a homework task would help me process between sessions.

As a therapist I sometimes think 'Well, we've talked about this already, and that hasn't worked, so I need to try a different approach', that is, there is something 'wrong' with the treatment strategies I'm using, or the original formulation. However, I found repetition of formulations, maintenance cycles, and alternative coping strategies really important. Often these things don't sink in first time around and need to be reiterated, rather than necessarily reinvented.

Difficulties that I had with CBT

Aside from the problems I had forming a trusting therapeutic relationship, I had several specific difficulties with CBT.

I am already quite a logical, scientific person. I come from a family in which 'be sensible and unemotional' were key messages. At first I felt that CBT was simply reinforcing these messages so I did not feel understood. I could, after all, be analytical and unemotional; but that was clearly insufficient on its own.

In a similar vein, I had gone too far with my version of self-CBT in that I went straight to analysing and changing my thoughts in a situation, giving no thought or weight to any feelings. I had used CBT to eradicate feelings from my life. I found it confusing that I was actually being encouraged to attend to feelings in therapy. I now understand that feelings are important too and shouldn't be completely ignored or reasoned away.

I didn't enjoy having my beliefs directly challenged; in fact I found this extremely uncomfortable. I think this is because I considered them to be 100% accurate and therefore not negotiable. They were 'facts' not 'thoughts'. They were also central to my identity and I didn't have any alternatives to believe. I also interpreted these challenges as meaning that 'my therapist thinks I'm stupid'. However, I can see that, in the long run, my discomfort may have been necessary. One of my beliefs was that I was 'the most terrible person in the world'. Now, with some distance from that belief, any approach other than questioning its validity doesn't really make sense. Sometimes though, an empathic, compassionate response helped much more than head-to-head challenging, particularly with regards to self-critical thoughts. I think it's really important to strike a balance between challenging beliefs and encouraging more rational responses, with validating a person's feelings and making sure they feel understood.

Advice for therapists

In one's attempt to be a good CBT therapist, I think it's crucial not to lose sight of the fundamental importance of a warm and strong therapeutic alliance.

For me therapy was helpful mainly because of this relationship. Specific cognitive behavioural techniques were less important, although conceptualizing problems using this model and being truly collaborative were essential. Also, don't underestimate the impact of giving a fundamentally human response to your client. I remember an occasion when I shared a belief about myself with my therapist. He simply looked me in the eye and said 'I don't think so'. That genuine response really surprised and affected me.

Try not to get bogged down by someone's complex history. Keep hopeful, it's contagious! I think my number of difficulties, on paper, could make me look like a real 'heart sink' patient. It is important to acknowledge, understand, and validate someone's history, but to remember that here-and-now change is absolutely possible, and probably needs to be the main focus. Also, sometimes the simplest techniques make the most impact; in my case the use of an activity diary.

Sometimes I think we assume that people who generate 'yes buts' in therapy 'don't want to change'; they are just unhelpfully coming up with difficulties, rather than gracefully accepting the sensible alternative suggested by the therapist! My 'yes buts' were frequent, but it was absolutely ok to express these. The therapist did not take them personally or respond to them in an irritated way, indeed he seemed genuinely interested in what the 'yes but' was. For me this was crucial—I could do the basic cognitive challenges but these 'yes buts' were really blocking me on a day-to-day basis outside of the therapy room.

Therapist enthusiasm and cheerfulness in response to my positive reports actually increased my anxiety ('now I'll be abandoned') and my feelings of guilt ('I'm bad so I don't deserve positive things'). For me it was much more rewarding to recognize that I was trying really hard and 'making some progress but not yet "better"'. This really enabled me to consolidate on any positive experiences I was having.

As a mental health professional I value kindness and have always felt uncomfortable being more challenging in style. However, this experience has reminded me that warmth and compassion are rarely enough on their own, particularly with complex difficulties. So now I spend a little less time being empathic, and a little more time being challenging. So far this change hasn't had any disastrous effects and seems to be helping people.

I think that in some spheres there is a tendency to be rather reductionist about CBT; that it's 'simply' about changing unhelpful patterns of thinking. Yet I experienced many of the intricacies of CBT, with a focus on meta-cognitive and interpersonal processes. My therapist clearly had CBT as his model but it's the process, the relationship and the learning through conversation that has made the most impact for me. For me professionally I have become aware that

there is enough to think about in order to do CBT well, without worrying about being integrative and using other therapeutic models.

What I think I'll have learnt

Reflecting on what I've learnt from therapy is difficult at the moment; as my CBT is ongoing; but I have a sense that its effects will be quite profound. There are a lot of specific things that I have learnt, for example, about the nature of feelings. Regular reference back to a formulation has helped me develop a less critical understanding of my difficulties. I am much less anxious, my self-esteem is improving, and my daily life is more manageable.

I know there will also be a lot of things that I will take away from therapy that it is harder to quantify. Most of these have been learnt through the therapeutic relationship. I have told someone all the 'terrible' things about me and he has not acted as though I am the worst person alive. The mere fact that someone has been prepared to give me his time, considered me worthy of help and persisted, despite my intransigence, means a great deal.

I think therapy is also changing my personality. It seems to be helping me form a sense of identity, feel braver about having opinions, and be more prepared to take risks. As my difficulties started as a young adolescent, I feel that therapy has given me the space and encouragement to grow up.

Key points

- ◆ CBT therapists have been slow to recognize the value of CBT for themselves both for professional and personal development. There are now a range of self-experiential options available to CBT therapists for enhancing skills, identifying and changing beliefs and assumptions, addressing personal problems, and engaging in other personal development. Possibilities range from SP/SR to personal therapy.
- ◆ Our choice of method to use for ourselves should be determined by a range of factors such as: our aims (personal growth, personal problems, or personal training?), our context (with others? colleagues, friends, not known?), ensuring a sense of safety, and ensuring we have the time, resources, and motivation to reflect and engage with the work.
- ◆ With the ever greater demands of CBT therapists, we may find considerable survival benefit in applying our tools of the trade to ourselves.

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