Evaluating the Effects of Self-Practice/Self-Reflection on Cognitive Flexibility, Empathy, Insight, Self-Compassion, Self-Monitoring, and Stress in Postgraduate Cognitive Behaviour Therapy Trainees

A thesis presented in fulfilment of the requirements for the degree of

Master of Arts

in

Psychology

at Massey University, Albany, New Zealand

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2017

Abstract

There is considerable evidence to suggest that cognitive behaviour therapy (CBT) training programs can effectively enhance therapists' CBT knowledge and skills. In response, research is now beginning to establish which specific training strategies are most effective in developing which CBT skills and competencies. Self-practice/self-reflection (SP/SR) is an experiential training strategy used to enhance CBT training and the ongoing professional development of CBT practitioners. Self-practice/self-reflection provides therapists with a structured experience of using CBT on themselves (self-practice) and reflecting on that experience (self-reflection). In order to build on previous SP/SR research, the aim of the current study was to explore the effects of SP/SR on six specific dimensions of CBT therapist competence: cognitive flexibility, empathy, insight, self-compassion, self-monitoring, and stress, among postgraduate CBT trainees. Seven students completing a SP/SR program as part of the Postgraduate Diploma in Cognitive Behaviour Therapy at Massey University were recruited to participate in the study. Quantitative data using six self-report measures of therapist competence was collected at five critical time points pertaining to the participants' SP/SR program: baseline, pre-intervention, midpoint, post-intervention, and follow-up. Qualitative data was collected from participants' written reflections. A mixed method design using descriptive quantitative and qualitative thematic analysis provided valuable quantitative (and some qualitative) support for the use of SP/SR as a CBT training and development strategy, particularly when targeting these six dimensions of CBT therapist competence.

Acknowledgements

This thesis would not have been possible on my own, and as such I would like to take this opportunity to thank those who have so generously contributed. First and foremost, I would like to offer my sincerest gratitude to my supervisor, Dr. Beverly Haarhoff. Your encouragement, wisdom, and gentle guidance has been invaluable, and I consider myself very fortunate to have had your support throughout this experience. I would also like to thank those who volunteered their time to participate in this study, without whom I would have nothing to write about. To my husband, Carl, thank you for making my life infinitely better and for supporting me always. I also want to thank my friend, Celia, for your daily encouragement and provision of sanity, and my family, for seeing the best in me.

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Chapter One: Introduction

Overview

Over the past four decades, cognitive behaviour therapy (CBT) has been well-established as an effective treatment for a wide range of psychological disorders (Rush, Beck, Kovacs, & Hollon, 1977; Roth & Fonagy, 2005; Butler, Chapman, Forman, & Beck, 2006; Stewart & Chambless, 2009). Using a variety of cognitive and behavioural techniques, CBT helps clients change unhelpful thinking and behaviour that can lead to enduring improvement in mood and functioning (Beck, 2011). Originally developed to treat depression, CBT is now considered the treatment of choice for many psychological disorders (Beck, 2011). As a result, there is an increasing demand for CBT trained therapists (McHugh & Barlow, 2010; Muse & McManus, 2013). However, although a strong empirical base has been established for CBT, research pertaining to CBT training has received far less attention and is relatively underdeveloped (Bennett-Levy, McManus, Westling, & Fennell, 2009).

The need for further CBT training research is highlighted by the considerable evidence suggesting a link between CBT therapist competence and client outcomes (Tsivrikos & Kuyken, 2009; Simons et al., 2010; Brown et al., 2013; Branson, Shafran, & Myles, 2015; Campos-Melady, Smith, Meyers, Godley, & Godley, 2017). Cognitive behaviour therapy training has been recognised as an essential component in the development of competent CBT therapists, and thus an important step in ensuring clients experience the best outcomes possible (Simons et al., 2010; Leffler, Jackson, West, McCarty, & Atkinson, 2013; Campos-Melady et al., 2017). Although research has established that CBT training programs can effectively improve therapists' CBT knowledge and skills, evidence is only just beginning to establish which specific training strategies are most effective in developing which CBT skills and competencies (Bennett-Levy, McManus et al., 2009). By strengthening the evidence base for

CBT training, current strategies can be refined in order to improve therapist competence and, subsequently, patient outcomes (Bennett-Levy, Lee, Travers, Pohlman, & Hamrnik, 2003; Bennett-Levy, McManus, et al., 2009; Thwaites et al., 2015).

This chapter begins by defining and introducing self-practice/self-reflection (SP/SR) as an important CBT training strategy. The declarative-procedural-reflective model of therapist skill development is then presented, providing a theoretical foundation for SP/SR. Next, workbooks as a tool to facilitate SP/SR are introduced, and the recently published workbook, *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists* (Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015), is outlined. The ways of being (WOB) model is introduced in the context of this workbook, and supporting evidence for the use of workbooks in SP/SR is presented. The relevant literature regarding SP/SR and CBT therapist development is then outlined, and separated into five sections: trainee therapist development, experienced therapist development, case conceptualisation, empathic skill development, and therapist self-care. Current limitations in SP/SR research are then introduced, and a chapter summary is provided before the research aims and rationale are presented.

Self-Practice/Self-Reflection

Self-practice/self-reflection (SP/SR) is an experiential training strategy conceptualised and developed by Bennett-Levy et al. (2001) and refined by Bennett-Levy, Thwaites, Haarhoff, and Perry (2015), and is used to enhance CBT training and the ongoing professional development of CBT practitioners. Self-practice/self-reflection provides therapists with a structured experience of using CBT on themselves (self-practice) and reflecting on that experience (self-reflection) (Bennett-Levy et al., 2015). In the context of CBT training, self-practice is defined as the experiential use of CBT techniques on oneself (Bennett-Levy et al., 2001). The rationale being that the therapist is able to "enter into the client's shoes" and "learn

by doing", as opposed to passively absorbing theoretical information (Bennett-Levy et al., 2001; Haarhoff & Farrand, 2012). Authors such as Bennett-Levy and Lee (2013) argue that this experiential self-practice facilitates a deeper understanding of CBT by aiding the transition of information from trainees' declarative knowledge (i.e., what to do) into procedural skills (i.e., how to do it). As Padesky (1996, p. 288) states, "To fully understand the process of the therapy, there is no substitute for using cognitive therapy methods on oneself."

Self-reflection (again in the context of CBT training) is defined as a process for therapists to reflect on both their personal self (e.g., actions or attitudes) and professional practice (e.g., skills or ability) (Bennett-Levy, Thwaites, Chaddock, & Davies, 2009). Research has increasingly recognised the influence therapists have on the therapeutic relationship (Beck, 2011), and the impact this can have on client outcomes (Gilbert & Leahy, 2007; Prochaska & Norcross, 2010), highlighting the need for CBT therapists to be able to "tune in" and attend to personal aspects of themselves. Self-reflection is believed to help therapists better acknowledge and address factors which can impact on interpersonal and therapeutic relational skills (Sanders & Wills, 2005; Bennett-Levy & Thwaites, 2007), and is thus increasingly considered an essential component of CBT training (Bennett-Levy, Thwaites et al., 2009).

In a SP/SR program, therapists choose either a professional or personal problem to focus on and use CBT strategies to identify, formulate, and address the problem, before reflecting on their experience of the techniques (Bennett-Levy et al., 2015). Self-practice/self-reflection can be used with both trainee therapists (to enhance CBT training) and experienced therapists (to facilitate ongoing professional development). There is a slowly growing body of literature that addresses the value and efficacy of SP/SR (Bennett-Levy, McManus et al., 2009; Gale & Shroder, 2014), which is generating increasing support for its use as a CBT training and professional development strategy for therapists of all skill levels (Bennett-Levy & Lee, 2013).

Declarative-Procedural-Reflective Model of Therapist Skill Development

Based on previous conceptualisations of knowledge processing (e.g., Binder, 1999; Skovholt & Ronnestad, 2001), the declarative-procedural-reflective (DPR) model of skill development was developed by Bennett-Levy (2006), and provides a theoretical foundation for SP/SR. The DPR model incorporates three interacting processing systems (see Figure 2): the declarative, procedural, and reflective systems. Declarative knowledge refers to theoretical and practical knowledge often obtained through didactic learning means, such as reading and attending lectures (Bennett-Levy, 2006). Procedural knowledge and skills, however, are developed over time in a more complex manner, and rely on one's ability to utilise experience in a meaningful way: therapists transition from a declarative system of knowing "what to do" to a procedural system of knowing "how to do it" (Bennett-Levy, 2006; Haarhoff & Thwaites, 2016). The reflective system refers to the way in which procedural knowledge is refined during experience, and is described as the "engine" which drives (and integrates knowledge from) the other two systems (Bennett-Levy, 2006; Haarhoff & Thwaites, 2016). The DPR model identifies reflection as central to therapist skill development, thus an important role is given to the reflective system which enables therapists to reflect and build on their conceptual (declarative) knowledge and procedural skills (Bennett-Levy, 2006).

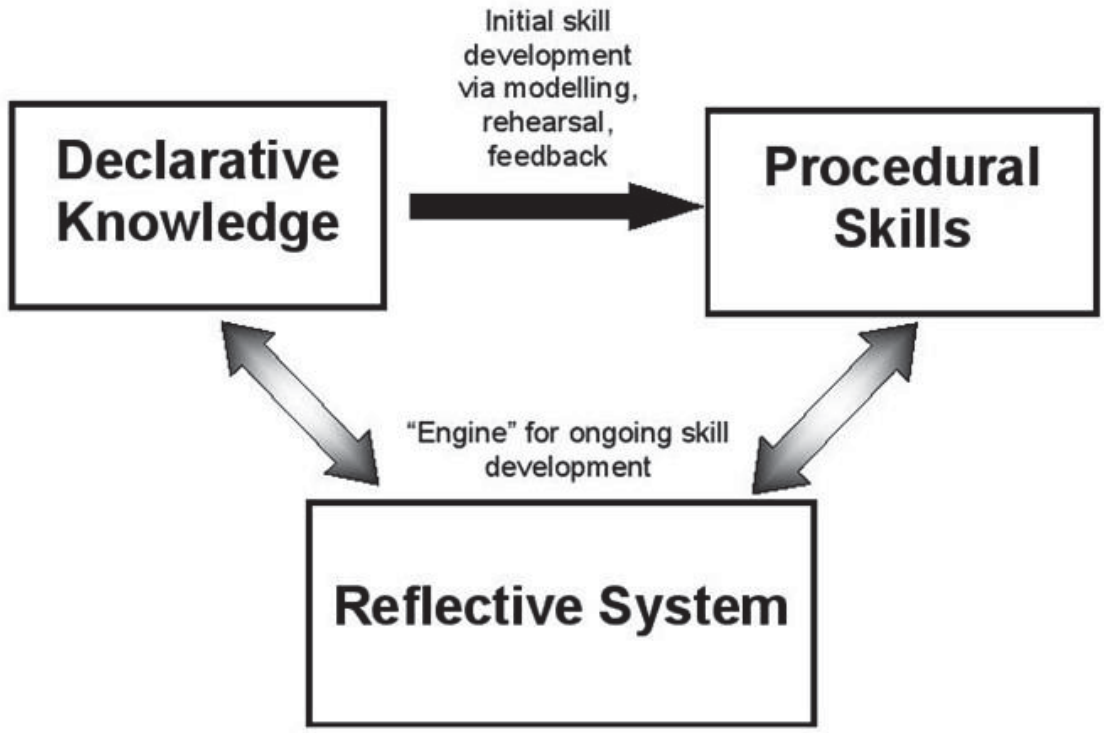

Figure 1. A simplified version of the declarative-procedural-reflective model (Bennett-Levy, Thwaites et al., 2009).

Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists

Background. While SP/SR has been incorporated into a number of CBT training and professional development programs (Bennett-Levy, McManus et al., 2009), it is worth noting that the mere act of allocating time for reflection in a program does not necessarily represent adherence to reflective practice (Farrand, Perry, & Linsley, 2010). In light of this, a number of specific methods used to facilitate SP/SR within CBT training have been developed: methods such as self-reflective journals, online blogs, and learning logs have all generated qualitative support for their role in facilitating SP/SR (Sutton, Townend, & Wright, 2007; Farrand et al., 2010). In an attempt to counter some of the weaknesses found within past SP/SR facilitatory tools (e.g., structure, direction, and accessibility), purpose-designed workbooks have also been

utilised (Bennett-Levy et al., 2001). Due to the relatively recent nature of SP/SR, only a small number of SP/SR studies have used purpose-designed workbooks, and even fewer studies have investigated their value in comparison to other facilitatory tools. However, there is evidence to suggest that SP/SR workbooks are an effective tool for facilitating SP/SR (e.g., Bennett-Levy et al., 2001; Bennett-Levy et al., 2003; Laireiter & Willutzki, 2003; Davis, 2008; Haarhoff, Gibson, & Flett, 2011; Davis, Thwaites, Freeston, & Bennett-Levy, 2014; Thwaites et al., 2015). This has resulted in the careful development and publication of *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists* (Bennett-Levy et al., 2015).

Workbook overview. *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists* (Bennett-Levy et al., 2015) is the first published SP/SR workbook. The starting point for the user is identifying, formulating, and addressing a professional or personal problem using CBT techniques, and reflecting on the experience (Bennett-Levy et al., 2015). The workbook consists of two parts: (I) Identifying and Understanding Unhelpful (Old) Ways of Being, and (II) Creating and Strengthening New Ways of Being. Each part comprises six modules (for a total of 12 modules): (1) Identifying a Challenging Problem, (2) Formulating the Problem and Preparing for Change, (3) Using Behavioural Activation to Change Patterns of Behaviour, (4) Identifying Unhelpful Thinking and Behaviour, (5) Using Cognitive Techniques to Modify Unhelpful Thinking and Behaviour, (6) Reviewing Progress, (7) Identifying Unhelpful Assumptions and Constructing New Alternatives, (8) Using Behaviour Experiments to Test Unhelpful Assumptions against New Alternatives, (9) Constructing New Ways of Being, (10) Embodying New Ways of Being, (11) Using Behavioural Experiments to Test and Strengthen New Ways of Being, and (12) Maintaining and Enhancing New Ways of Being. The first six modules are completed weekly, and the second six modules are completed fortnightly. Each module consists of a number of

exercises that are worked through independently, in addition to a list of self-reflective questions. At the conclusion of each module, users complete a written reflection (using the self-reflective questions provided), which is then ideally shared with other therapists (e.g., in an online forum or group reflection session with other therapists engaging in SP/SR, or with a colleague or supervisor in a professional setting).

Ways of being model. The ways of being (WOB) model is a transdiagnostic, strengths-based approach, which emphasises the value of experiential techniques in promoting change (Bennett-Levy et al., 2015). Based on Teasdale and Barnard's interacting cognitive subsystems (ICS) model (1993), the WOB model is used to give coherence to the SP/SR workbook and to provide an overall framework. The first six modules (Part I of the workbook) are focused on identifying and understanding "old/unhelpful ways of being". An example of this is a "stuck" belief or pattern of behaviour, such as "I'm no good at helping people with severe depression" (Bennett-Levy et al., 2015). A perspective shift is encouraged by helping therapists to develop a different relationship to their thoughts through distancing or mindfulness strategies: thoughts are no longer "facts" but opinions, ideas, or transient cognitive experiences open to validation and invalidation (Bennett-Levy et al., 2015). The second six modules (Part II) of the workbook are focused on creating "new ways of being" based on this perspective shift. For example, the consideration that a number of clients experiencing severe depression do not recover, regardless of the expertise of the therapist, may initiate a "new way of being" (e.g., "I'm doing alright as I am, and my competency is continuing to develop") which can be strengthened over time.

Supporting evidence. Due to the recent publication of *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists*, only one published study has used this particular workbook as a tool to facilitate SP/SR. In their recent study, Thwaites et al. (2015) investigated the effects of a SP/SR program undertaken by seven experienced low-

intensity CBT therapists, facilitated by the SP/SR workbook, *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists* (Bennett-Levy et al., 2015). Participants used the following measures to track their experience of the program: time spent on program, personal and therapy related belief ratings, goals attained, and perceived skill ratings for average and most difficult patients. The results indicated a positive change in work-related skill and behaviour change, particularly when working with the more difficult patients. These findings suggest that *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists* may be a useful tool in facilitating SP/SR among experienced low-intensity CBT therapists.

Further support for the use of SP/SR workbooks in general can be found in Davis' (2008) quasi-experimental investigation of the effects of SP/SR workbooks on the self-perceived therapeutic skill, personal-self and self-as-therapist beliefs, and empathy of seven experienced CBT therapists. Participants were randomly allocated to one of four baseline dates, and each completed a structured SP/SR workbook which guided them through specific SP/SR exercises over a 10-week period. A written reflection pertaining to each exercise was handed in at the end of each week. Quantitative data was gathered using weekly self-ratings of self-perceived cognitive therapist skills, empathic skills, and key beliefs and the personal and therapist self. Additional measures utilised throughout the study included the Cognitive Therapist Self-Monitoring Scale (Thwaites et al., 2008), the Cognitive Therapist Empathy Scale (Thwaites, Armstrong, & Cromarty, 2003), and a trainee-constructed Idiographic Self-Monitoring Scale. Qualitative data was gathered using weekly SP/SR reflections in addition to a follow-up semi-structured interview.

Following the completion of the SP/SR workbook, analysis of the data revealed significant improvements in participants' self-rated cognitive therapy and empathy skills, compared to scores at baseline. Moderate reductions in dysfunctional belief ratings (regarding

personal- and therapist-self) were also observed. Thus, despite a small number of methodological limitations (e.g., sampling restrictions), the results provided early quantitative support for the use of purpose-designed workbooks to facilitate SP/SR. Davis' (2008) findings quantitatively suggest not only that SP/SR may be an effective training strategy to enhance therapeutic skill in experienced CBT therapists, but that SP/SR workbooks may be an effective method to support this process.

Self-Practice/Self-Reflection and Therapist Development

According to Bennett-Levy (2003), SP/SR has been found to have a self-reported impact at three levels: (1) conceptual (therapeutic understandings, e.g., trainees describe enhanced understanding of the role of therapist and change processes), (2) practical (therapist skills, e.g., therapists report that they are better at communicating the conceptual framework of CBT, and establish a stronger therapeutic bond), and (3) attitudinal (therapist self-concept, e.g., therapists report that they have greater belief in CBT, having experienced some of its effects internally, and have greater confidence as a therapist). Further research regarding the impact of SP/SR on CBT therapist development is presented in this section: trainee therapist and experienced therapist research is presented sequentially, in addition to specific findings regarding CBT case conceptualisation and therapist empathic skill. This section also introduces the issue of therapist self-care and its relevance to SP/SR research.

Trainee therapist development. In their seminal study, Bennett-Levy et al. (2001) investigated the value of SP/SR and its effect on CBT training. Two groups of postgraduate clinical psychology trainees (n=19) completed a SP/SR program as a formal course requirement. Group One completed a minimum of five self-practice exercises that included elements of both thought records and behavioural experiments. Self-reflection was encouraged following the exercises, but the format of this reflection was left to the trainees' discretion. In

addition, Group One submitted a 1000-word reflective paper outlining learned experiences from the self-practice exercises. In contrast, participants in Group Two completed a purpose-developed SP/SR workbook: each week participants were required to apply at least one CBT technique on themselves before writing a reflection about their experience. Data was gathered from participants' written reflections, in addition to transcribed audiotapes from group reflections (Group One) and semi-structured interviews (Group Two). Due to the exploratory focus of the research, an inductive qualitative methodology was used: grounded theory was used to facilitate the emergence of a new theory. In addition, practitioner-researcher self-study and participative action research were also utilised.

The findings indicated that the use of SP/SR (with or without workbooks) was unanimously perceived as beneficial to therapeutic development. As such, Bennett-Levy et al. (2001) developed a model to conceptualise the findings regarding the impact of SP/SR on CBT training. which outlines both process and outcome mechanisms (see Figure 2). Although 90% of the data related to the outcome of therapeutic understanding, it was also noted that this increased understanding further worked to enhance therapist skills (e.g., enhanced empathy) and self-concept (e.g., perception of competence). Therefore, the results provided tentative support for the use of SP/SR as a beneficial training strategy for trainee therapist development, in addition to demonstrating that workbooks were at least equally helpful as other means (e.g., those used by Group One) in facilitating SP/SR.

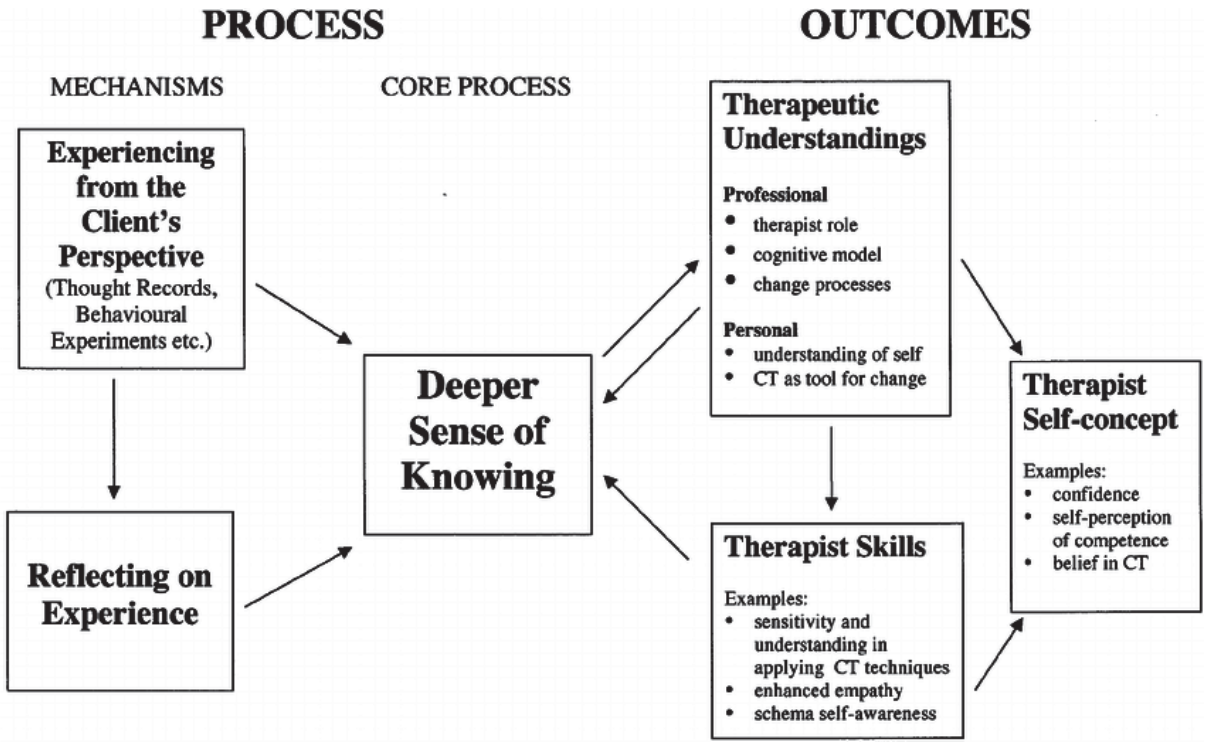

Figure 2. Proposed model of impact of SP/SR by Bennett-Levy et al. (2001, p. 210).

Experienced therapist development. According to Davis et al. (2014), the need for effective training methods for enhancing CBT competency is not only relevant to trainee therapists but also to experienced therapists looking to retain and further enhance their skills. In light of this, Davis et al. aimed to quantify the impact of a SP/SR program on the therapeutic skills of 14 experienced CBT therapists. The study used a quasi-experimental design including multiple baselines within a single-case methodology. The participants provided self-ratings of technical CBT skill and interpersonal empathic skill at four critical stages pertaining to the SP/SR program: baseline, pre-SP/SR, post-SP/SR, and follow-up. Analysis of program completers (n = 7) indicated that SP/SR enhances both technical skill and interpersonal therapeutic skill. Further intention-to-treat group analyses (n = 14) added to the robustness of findings regarding technical CBT skills, but not interpersonal empathic skills. Thus, it was concluded that SP/SR, as a training and development program, could offer an avenue to further therapeutic skill enhancement in experienced CBT therapists.

Further support for the use of SP/SR with experienced therapists can be found in Bennett-Levy, Lee, Travers, Pohlman, and Hamrnik's (2003) study, aiming to map the impact of SP/SR on CBT skills in a group of experienced CBT therapists. Fourteen experienced CBT therapists engaged in training courses utilising SP/SR: six therapists from one training group engaged in "co-therapy" sessions with a partner, while eight therapists from another training group practiced CBT techniques on their own. Both groups engaged in regular written reflections about their experiences. Follow-up took place 1 – 5 months after the courses ended, and identified six areas of self-reported skill enhancement: (1) CBT skills, (2) communication of the conceptual framework of CBT, (3) attention to the therapeutic relationship, (4) empathy, (5) therapist self-reflection, and (6) cognitive flexibility. The results suggested that SP/SR enhances the "professional artistry" of therapists, a finding consistent with literature suggesting that self-reflection is a key process in therapist development. Thus, it was concluded that SP/SR represents a promising training and development strategy for experienced CBT therapists.

Case conceptualisation. Using the DPR model of therapist skill acquisition (outlined previously), Haarhoff, Gibson, and Flett (2011) sought to investigate how different kinds of knowledge systems can be integrated to enhance CBT therapist skill acquisition and, consequently, therapist development. Sixteen recent graduates of a postgraduate diploma in CBT (including both trainee and experienced therapists) independently completed a SP/SR workbook. The workbook was specifically designed to lead the participants through a series of CBT interventions commonly used to elicit the information required for a CBT case conceptualisation. In addition, participants completed written reflections regarding their experience of the interventions. The participants' self-reflections were thematically analysed and uncovered the following inter-related themes: increased theoretical understanding of the CBT model, self-awareness, empathy, conceptualisation of the therapeutic relationship, and adaptation of clinical interventions and practice. Thus, it was tentatively concluded that

targeted SP/SR enhanced CBT case conceptualisation skill by consolidating the declarative-procedural-reflective systems important in therapist skill acquisition.

Empathic skill development. In a meta-synthesis of qualitative studies exploring therapists' experiences of SP/SR in CBT, Gale and Shroder (2014) integrated and interpreted the current literature in order to develop a new understanding, and contribute to the further development of CBT training programs and, consequently, therapist development. A comprehensive and systematic literature search was conducted, followed by the critical appraisal of papers, and a synthesis of data using the meta-ethnographic method. Of the 378 papers identified in the literature search, 10 met the criteria for inclusion (and were all included in the synthesis). The synthesis identified 14 constructs, which fell into three categories: experience of SP/SR, outcomes of SP/SR, and implications for training. The synthesis found that self-practice allows therapists to put themselves into their clients' shoes, experiencing both the benefits that therapy can bring and the problems that clients can encounter. This experience increases therapists' empathy for their clients, and allows them to utilise their own experiences in therapy. As a result of this enhanced empathy, therapists tend to feel more confident in themselves and more competent as a therapist. The findings provided evidence for SP/SR as a valuable CBT training strategy, in addition to a means of continuing personal and professional development. The findings also highlighted empathy as a specific therapist competency positively impacted by SP/SR leading to a range of beneficial outcomes.

Therapist self-care. Research suggests that both CBT training and therapist practice can be extremely challenging: mental health practitioners consistently report high levels of occupationally-related stress, which can lead to a number of physical and/or psychological problems (Tyler & Cushway, 1998; Kottler, 2012; Haarhoff & Thwaites, 2016). As a result, research has increasingly recognised therapist self-care as an important component of therapist competence. Self-care can be defined as making an active choice to take care of yourself in

terms of basic physical needs (e.g., eating, sleeping, and exercising) as well as in an emotional, interpersonal, occupational, and spiritual sense (Ziguaras, 2004). Therapist self-care primarily consists of knowing what self-care is, recognising potential barriers to self-care, and knowing how to enhance self-care as a therapist (Haarhoff & Thwaites, 2016). Researchers such as Haarhoff and Thwaites (2016) suggest that SP/SR may be helpful in enhancing CBT therapists' self-care skills, and thus in reducing the problems associated with therapist stress. However, further research is required to better understand the potential role of SP/SR in therapist self-care.

Self-Practice/Self-Reflection Research Limitations

A systematic literature review, conducted by McGillivray, Gurtman, Boganin, and Sheen (2015), investigated the effects of SP/SR on therapist development. Studies were identified using a number of databases, in addition to later searches of relevant papers' reference lists and direct correspondence with authors of unpublished material. All studies that investigated the effects of self-practice and/or self-reflection on therapist development were included in this review (n = 10). The qualitative data was analysed using thematic analysis. The quantitative data was not subject to a meta-analysis, due to inconsistency in the variables measured, and was simply recorded instead. The meta-synthesis revealed inconsistencies between the qualitative and quantitative literature, in addition to a gap regarding declarative knowledge.

The review findings draw attention to the paucity of SP/SR literature, particularly regarding specific CBT therapist skills: most studies to date have not investigated the effects of SP/SR in relation to specific therapist skills, but rather whether SP/SR has any effect on CBT therapist development. This highlights the need for further SP/SR research in general, in addition to research regarding its effects on specific CBT therapist skills and competencies.

Furthermore, most studies regarding SP/SR have been conducted by the original developers of the method, suggesting an additional need for independent research. The review also reveals inconsistencies within the current literature in relation to methodological design and results, and a gap in the literature regarding declarative knowledge. It is recommended that homogeneity of methodological design be increased in future research to allow for comparability and to enhance the reliability of findings, and that quantitative research methods be employed to address the declarative knowledge deficit.

Summary

There is considerable evidence to suggest that CBT training programs can effectively enhance therapists' CBT knowledge and skills, thus research is now beginning to establish which specific training strategies (e.g., SP/SR) are most effective in developing which CBT skills and competencies (e.g., empathic skill). The DPR model emphasises reflection in therapist skill development, providing a theoretical framework for SP/SR (Bennett-Levy, 2006). Furthermore, the literature regarding SP/SR is generating increasing support for its use as an experiential CBT training and professional development strategy for therapists of all skill levels (Bennett-Levy, McManus et al., 2009; Bennett-Levy & Lee; 2014; Gale & Shroder, 2014). Research also suggests that SP/SR workbooks effectively provide a structured and experiential approach to facilitate SP/SR (e.g., Davis, 2008; Thwaites et al., 2015).

Evidence supports the use of SP/SR with both trainee therapists (e.g., Bennett-Levy et al., 2001) and experienced therapists (e.g., Bennett-Levy et al., 2003; Davis, 2015). Furthermore, research suggests that SP/SR may effectively enhance therapists' CBT knowledge and case conceptualisation skills (e.g., Bennett-Levy et al., 2001; Bennett-Levy et al., 2003; Davis, 2008; Haarhoff et al., 2011; Davis et al., 2014), as well as therapists' empathic skills (e.g., Bennett-Levy et al., 2001; Bennett-Levy et al., 2003; Davis, 2008; Gale & Shroder,

2014; Davis et al., 2014). Additional skills that may be positively impacted by SP/SR include cognitive flexibility, self-reflection (and consequently self-care), insight, and self-awareness (i.e., self-monitoring) (Bennett-Levy et al., 2001; Bennett-Levy et al., 2003; Haarhoff et al., 2011; Haarhoff & Thwaites, 2016). Although not yet directly investigated (in relation to SP/SR), therapist self-care is recognised as an important aspect of CBT therapist competence, and research is needed to better understand the potential role of SP/SR on the development of self-care skills (e.g., self-compassion). In addition, a number of limitations within the current SP/SR literature have been identified such as (1) a general paucity of SP/SR research, particularly regarding its impact on specific therapist skills and competencies, (2) a lack of independently conducted studies, (3) inconsistencies in methodological design, and (4) a distinct lack of quantitative studies (McGillivray et al., 2015).

Current Research Aims and Rationale

The current research aims to explore the effects of SP/SR on six specific dimensions of CBT therapist competence: cognitive flexibility, empathy, insight, self-compassion, self-monitoring, and stress, among postgraduate CBT trainees completing the workbook, *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists* (Bennett-Levy et al., 2015) as part of their training. A number of factors contributed to the selection of these six dimensions: firstly, there is comparatively substantial support in the literature for the use of SP/SR to enhance therapist empathy. However, as the vast majority of studies thus far have been qualitative, this therapist competency was selected in an attempt to provide quantitative support for the current findings. Secondly, evidence has suggested that SP/SR may also enhance therapists' cognitive flexibility (i.e., the ability to shift one's thinking between different concepts), insight, and self-monitoring (i.e., self-awareness) skills. Due to a general paucity of research (particularly quantitative), these three skills were selected to better understand how they are each impacted by SP/SR and to provide quantitative support for the

existing findings. Finally, in an attempt to explore the role of SP/SR in enhancing therapist self-care skills (and consequently reducing the negative effects associated with therapist stress), self-monitoring and stress were additionally selected for investigation. Qualitative research has reasonably well-established that SP/SR enhances CBT therapists' declarative knowledge and procedural skills (see Figure 1) and, consequently, case conceptualisation skills. As such, this broad dimension of therapist competence was excluded from the current study. In order to promote homogeneity (and thus increase research comparability and enhance reliability), a quantitative methodology was employed using self-report measures to evaluate each of the six CBT therapist skills and competencies.

Chapter Two: Method

Overview

This chapter begins by describing the participants involved in the study, followed by the measures used: six quantitative self-report measures are outlined, in addition to the SP/SR workbook introduced in the previous chapter. The study's mixed-method research design is presented, and the procedure outlined: both quantitative and qualitative data collection and analysis methods are described.

Participants

The participants were seven out of eight students enrolled in the Postgraduate Diploma in Cognitive Behaviour Therapy at Massey University. This is a 120-point postgraduate qualification completed part-time over two years. To be eligible for the Postgraduate Diploma, students must have a Bachelor's degree from a New Zealand tertiary institution (or the equivalent) and relevant work experience in mental health. The qualification consists of four 15-point papers (175.761 Theory and Practice of CBT, 175.762 CBT for Depression, 175.763 CBT for Anxiety Disorders, and 175.764 CBT for Chronic and Complex Disorders) and a 60-point clinical practicum (175.765 CBT Clinical Practicum). Self-practice/self-reflection is incorporated into the clinical practicum as an 18-week program using the workbook, *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists* (Bennett-Levy et al., 2015).

Demographic information was collected from six out of seven participants. All participants were female, and ranged in age from 33 to 57 years (*mean* = 47.5 years). The participants belonged to a range of professional disciplines: counselling (*n* = 2) social work (*n* = 2), and nursing (*n* =2), and were employed in both public and private mental health settings throughout the study. The participants' experience working in mental health ranged from 4 to

20 years (*mean* = 10.3 years). All eight students enrolled in the Postgraduate Diploma in Cognitive Behaviour Therapy were eligible to participate. Each student was provided with an information sheet outlining the study and their rights as participants, and a $50 voucher was offered as an incentive for volunteering. All participants provided their written consent prior to the commencement of the study (only one student neglected to participate, for reasons unknown).

Measures

Quantitative measures. Six quantitative self-report measures were used: the adapted Cognitive Therapist Empathy Scale v3.0 (Thwaites et al., 2008), adapted Cognitive Therapist Self-Monitoring Scale (Thwaites et al., 2003), Cognitive Flexibility Inventory (Dennis & Vander Wal, 2010), Perceived Stress Scale (Cohen, Carmarck, & Mermelstein, 1983), Self-Compassion Scale – Short Form (Raes, Pommier, Neff, & Van Gucht, 2011), and Self-Reflection and Insight Scale (Grant, Franklin, & Langford, 2002).

The adapted Cognitive Therapist Empathy Scale (CTES) v3.0 (Thwaites et al., 2008) is a quantitative self-report measure consisting of 18 items, and is used to measure therapists' empathy when dealing directly with clients (see Appendix A). Each item is a statement such as, "I have been able to convey to my client(s) that the way they are feeling is understandable". The participants were asked to specify the extent to which they agreed or disagreed with each statement using a 100-point rating scale, from *completely disagree* (0) to *completely agree* (100). The adapted CTES takes approximately 5 – 10 minutes to complete. Participants were asked to complete the scale in relation to their practicum client, as part of the Postgraduate Diploma in Cognitive Behaviour Therapy, or a client seen in the last seven days if this was not possible. The original scale consisted of two different ratings for each item: a general rating in relation to all clients seen in the last seven days, and a specific rating in relation to the client

deemed most difficult that week. These ratings were replaced with the single rating described above in order to simplify the scale and focus the participants' responses on the clients seen as part of their studies.

The adapted Cognitive Therapist Self-Monitoring Scale (CTSMS) (Thwaites et al., 2003) is a quantitative self-report measure consisting of 12 items, and is used to measure therapists' self-monitoring skills in regards to their own therapeutic practice (see Appendix B). Each item states a skill such as, "Collaboration. E.g. Encouraging patients to be active in sessions and participate actively in therapeutic teamwork". The participants were asked to rate their competence for each item using a 100-point rating scale, from *novice* (0) to *expert* (100). The adapted CTSMS takes approximately 5 – 10 minutes to complete. Again, participants were asked to complete the scale in relation to their practicum client, as part of the Postgraduate Diploma in Cognitive Behaviour Therapy, or a client seen in the last seven days if this was not possible. As for the adapted CTES v3.0, the original scale consisted to two different ratings for each item: a general rating in relation to all clients seen in the last seven days, and a specific rating in relation to the client deemed most difficult that week. These ratings were again replaced with the single rating described above in order to simplify the scale and focus the participants' responses on the clients seen as part of their studies.

Both the CTES and CTSMS were originally developed in 2003 by tutors of two CBT training courses piloting SP/SR with their trainees, and in need of a sensitive measure for empathy and self-monitoring skills (Thwaites et al., 2003). The measures have since been altered for use with both trainee and experienced therapists (Davis et al., 2014). Due to the primarily qualitative nature of SP/SR studies to date, the CTES and CTSMS have only been used in a small number of studies, and research regarding the scales' psychometric properties have yet to be conducted. However, Chaddock et al. (2014) employed both measures in their study regarding individual differences in response to SP/SR during CBT training. In addition,

Davis et al. (2014) used the measures in their study investigating the effects of SP/SR on the therapeutic skills of 14 experienced CBT therapists (previously outlined in chapter one). Both scales were found to have excellent internal consistency: a Cronbach's alpha of .92 was calculated for the CTES, and .96 for the CTSMS (Davis et al., 2014).

The Cognitive Flexibility Inventory (CFI) (Dennis & Vander Wal, 2010) is a quantitative self-report measure consisting of 20 items, and is used to measure cognitive flexibility (see Appendix C). This scale comprises two subscales: alternatives and control. A sample statement used to measure alternatives is, "I have a hard time making decisions when faced with difficult situations". A sample statement used to measure control is, "I find it troublesome that there are so many different ways to deal with difficult situations". The participants were asked to rate their agreement with each statement on a 7-point Likert scale: *strongly disagree* (1), *disagree* (2), *somewhat disagree* (3), *neutral* (4), *somewhat agree* (5), *agree* (6), and *strongly agree* (7). The CFI takes approximately 10 – 15 minutes to complete, and was originally developed to measure the type of cognitive flexibility necessary for individuals to successfully challenge and replace maladaptive thoughts with more balanced and adaptive thinking (Dennis & Vander Wal, 2010). Research investigating the psychometric properties of the CFI found it to have a reliable two-factor structure, good to excellent internal consistency, and high 7-week test-retest reliability (e.g., Dennis & Vander Wal, 2010; Johnco, Wuthrich, & Rapee, 2014).

The Perceived Stress Scale (PSS) (Cohen, Carmarck, & Mermelstein, 1983) is a quantitative self-report measure consisting of 10 items, and is used to measure the degree to which situations in one's life are perceived as stressful (see Appendix D). Each item is a question such as, "In the last month, how often have you felt confident about your ability to handle your personal problems?". The participants were asked to specify the frequency with which they had thought or felt the way each question described using a 5-point Likert scale:

never (0), *almost never* (1), *sometimes* (2), *fairly often* (3), and *very often* (4). The PSS takes approximately 5 – 10 minutes to complete. The PSS is the most widely used psychological instrument for measuring the perception of stress (Cohen, Kamarck, & Mermelstein, 1983), and considerable research regarding its psychometric properties has well-established its reliability and validity (e.g., Reis, Hino, Rodriguez-Anez, 2010; Andreou et al., 2011; Nordin & Nordin, 2013; Smith, Rosenberg, & Timothy Haight, 2014; Eskildsen et al., 2015; Miner, Schueller, Lattie, & Mohr, 2015; Khalili, Sirati nir, Ebadi, Tavallai, & Habibi, 2017).

The Self-Compassion Scale – Short Form (SCS-SF) (Raes, Pommier, Neff, & Van Gucht, 2011) is a quantitative self-report measure consisting of 12 items, and is used to measure self-compassion (see Appendix E). The scale comprises six subscales: self-kindness (e.g. "I try to be understanding and patient towards those aspects of my personality I don't like"), self-judgment (e.g. "I'm disapproving and judgmental about my own flaws and inadequacies"), common humanity (e.g. "I try to see my failings as part of the human condition"), isolation (e.g. "When I fail at something that's important to me, I tend to feel alone in my failure"), mindfulness (e.g. "When something painful happens I try to take a balanced view of the situation"), and over-identification (e.g. "When I'm feeling down I tend to obsess and fixate on everything that's wrong"). The participants were asked to specify the frequency with which they had thought or felt the way each statement described using a 5-point Likert scale, from *almost never* (1) to *almost always* (5). The SCS-SF takes approximately 5 – 10 minutes to complete, and was developed by Raes et al. (2011) as a shortened version of the long SCS. In their developmental study, two Dutch samples were used to construct and cross-validate the factorial structure of the SCS-SF, and a third English sample was used to validate the scale. The findings demonstrated adequate internal consistency (Cronbach's alpha > 0.86 in all samples), as well as a near-perfect correlation with the long form SCS ($r > 0.97$ in all samples) when examining total scores, and is therefore ideally suited for the purposes of this study.

The Self-Reflection and Insight Scale (SRIS) (Grant, Franklin, & Langford, 2002) is a quantitative self-report measure consisting of 20 items, and is used to measure self-reflection and insight (see Appendix F). The scale comprises three subscales: engagement in self-reflection, need for self-reflection, and insight. A sample statement used to measure engagement in self-reflection is, "I don't often think about my thoughts", and to measure need for self-reflection is, "It is important for me to evaluate the things I do". A sample statement used to measure insight is, "I am usually aware of my thoughts". The participants were asked to specify the extent to which they agreed or disagreed with each statement using a 6-point Likert scale: *disagree strongly* (1), *disagree* (2), *slightly disagree* (3), *slightly agree* (4), *agree* (5), and *agree strongly* (6). The SRIS takes approximately 10 – 15 minutes to complete, and was originally developed as a progression of the Private Self-Consciousness Scale (Fenigstein, Scheier, & Buss, 1975). The SRIS has since been utilised in a broad range of studies (e.g., Grant & Cavanagh, 2007; Xu, 2011; Kuklick, Gearity, & Thompson, 2015; Pai, 2015). Roberts and Stark (2008) undertook a confirmatory factor analysis of the SRIS, and found it to be a reliable measure of both self-reflection and insight with good construct and content validity.

Qualitative measures. The SP/SR workbook, *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists* (Bennett-Levy et al., 2015), as outlined in chapter one. The participants' written reflections (pertaining to each of the 12 modules) are shared in an online forum with the other students enrolled in the Postgraduate Diploma. In order to provide a succinct overview of the participants' experience of the SP/SR program in its entirety, the two review reflections from Module 6 and 12 were selected for qualitative thematic analysis. The Module 6 ("Reviewing Progress") reflection reviewed Part I of the SP/SR workbook (modules 1-6), and consisted of seven self-reflective questions, outlined below.

1. You have now completed half of the workbook. How would you summarise your overall reaction to the self-practice exercises thus far? Is there a difference between what you have experienced at a rational intellectual level and what you may have felt at a "gut level"?
2. Have any of your experiences of self-practice particularly stood out for you? If so, how would you account for this?
3. This module has focused on reviewing your SP/SR progress and identifying roadblocks. Have you discovered anything about yourself in this context? Did you notice any self-criticism relating to your engagement with SP/SR? If so, how did this feel? Are there any ways that you could use this as an opportunity to relate to yourself in a different (e.g., more compassionate) way?
4. When you consider the impact of the SP/SR thus far, have you experienced this as mainly affecting your "personal self" or your "therapist self", or both? How do you think your personal and professional learnings relate to one another?
5. Can you bring to mind a particular client who may be experiencing difficulty in progressing? Is there anything you have learned from reviewing your own progress that might be relevant for this client? If so, how will you put this into practice? When? Where? How?
6. What has been your reaction to the self-reflective questions at the end of each module? Can you identify any difficulties with the reflective process? Are there any steps you can take to improve this experience for yourself?
7. Is there anything else you've noticed in this module that you think might be important to remember and come back to later?

The Module 12 ("Maintaining and Enhancing New Ways of Being") reflection reviewed Part II of the SP/SR workbook (modules 7-12), and again consisted of seven self-reflective questions, outlined below.

1. Which of the *New Ways of Being* strategies have been most effective in building your belief in your new ways of thinking, and creating new behaviours and underlying patterns?
2. From your experience of *CBT from the Inside Out*, how do you understand the relationship between experiential and cognitive strategies, and their relative effectiveness? How do you think experiential and cognitive strategies can be best interweaved?
3. What did you notice about creating an explicit, written My *New Ways of Being* Maintenance Plan? Were there any thoughts, emotions, or behaviours that surprised you?
4. How has developing a personal My *New Ways of Being* Maintenance Plan for yourself influenced what you might do in your therapy practice in the future?
5. How would you sum up your experience of *Experiencing CBT from the Inside Out*?
6. After completing this workbook what do you consider the most important "take-home" messages to be: From a professional perspective? From a personal perspective?
7. Do you consider that it would be of value to continue with SP/SR in the future? If so, how might you do so? What steps could you take to ensure that this becomes a regular part of your professional life? Is there anything that might get in the way of this?

Research Design

The study aimed to evaluate the effects of SP/SR on six specific dimensions of competence: empathy, cognitive flexibility, insight, self-compassion, self-monitoring, and stress. To achieve this, the study sought to quantitatively measure each of these skills or

competencies at various stages of a SP/SR program, in addition to descriptively investigating participants' perceptions of the effects of SP/SR. A mixed design using descriptive quantitative and qualitative methods was regarded as the best approach. Descriptive quantitative data of participants' measure scores pertaining to each specific therapist skill allowed the researcher to evaluate each participants' skill level at different stages of SP/SR.

Thematic analysis was chosen as the theoretical framework for the qualitative data, as it provides a flexible, detailed, and complex account of individuals' experiences (Braun & Clarke, 2006), particularly from those within small pre-defined samples (Patton, 2002). Additionally, its generalisability across a range of theoretical approaches (Braun & Clarke, 2006) suitably accommodate the authors post-positivist essentialist/realist epistemology. Thereby, a deductive theoretical thematic analysis was used to identify and analyse relevant themes within the data. This provided an in-depth understanding of participants' experience of SP/SR, in addition to gaining insight in terms of the effects of SP/SR that extend beyond the six dimensions of therapist competence focused on (Braun & Clarke, 2006).

Procedure

Ethics. The research proposal was discussed with the researcher's supervisor and reviewed by another staff member, and deemed low risk. Thus, it was not necessary for review by Massey University's Human Ethics Committee. Before beginning the study, participants were sent an information sheet outlining the study and their rights as participants (see Appendix G), and written consent was obtained (see Appendix H). Each participant was allocated a number between 1 – 7 to be used as identification. This gave the participants anonymity while allowing the researcher to identify each participant's complete data set for analysis purposes.

Data collection. The primary data collection mode used was repeated self-report measures. The six quantitative self-report measures described above were sent to participants

(via post) at five different stages relating to the participants' 18-week SP/SR program (see Figure 3): three weeks before the program began (stage 1 – *baseline*), one week before the program began (stage 2 – *pre-intervention*), halfway through the program (stage 3 – *midpoint*), one week after the program ended (stage 4 – *post-intervention*), and 10 weeks after the program ended (stage 5 – *follow-up*). The measures were posted to the participants approximately 10 working days prior to each data-collection point, which gave participants approximately five working days to complete each set of measures before returning them. Instructions on how and when to return the completed measures were included with each set (see Appendix I). Each participant completed all six measures at the five different stages outlined above, and returned the completed measures in the enclosed self-addressed and prepaid envelope each time.

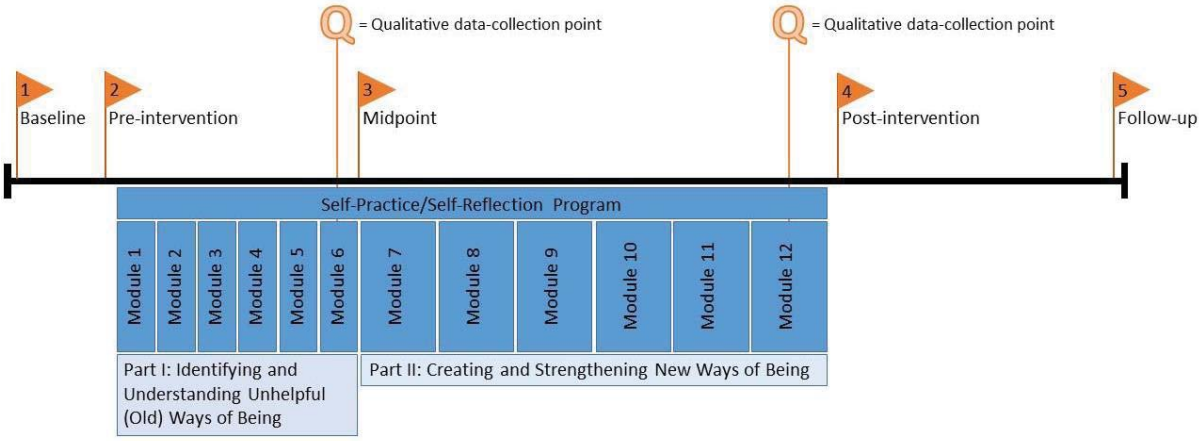

Figure 3. The five data collection stages relating to the participants' 18-week self-practice/self-reflection program.

Qualitative data was also used. Following the completion of the SP/SR program, the study's author was granted access to the online forum in which the participants shared their written reflections with one another. All seven participants submitted a written reflection for Module 6, "Reviewing Progress", and six out of seven participants submitted a written reflection for Module 12, "Maintaining and Enhancing New Ways of Being". Thus, the

qualitative data was gathered solely from participants' written responses to the self-reflective questions (outlined above) pertaining to Module 6 and 12 of the SP/SR workbook.

Data analysis. The quantitative data was treated using both visual inspection and statistical analysis. The statistical analysis was carried out using IBM SPSS Statistics 24 (IBM Corp, 2016). Due to the small sample size, inferential analysis was not conducted. It is worth nothing that although a relatively small number of participants were included in this study, the sample represents a significant proportion of therapists undertaking a postgraduate qualification in CBT in New Zealand at this time. In order to accommodate the small sample size, the quantitative data was treated both as a group and as seven individual case studies.

The qualitative data was analysed using thematic analysis, conducted in accordance with Braun and Clarke's (2006) six-phase guide for performing thematic analysis. Phases included: (1) familiarising oneself with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) establishing the results and presenting the outcomes. Themes pertaining to participants' experience of the SP/SR program were identified according to both prevalence and perceived importance.

Chapter Three: Results

Overview

This chapter draws upon both quantitative and qualitative data to present findings that arose from data analysis. Firstly, the quantitative descriptive analysis results are presented for the six measures outlined above, both as a group (sorted by measure) and as seven individual case studies (sorted by participant). Secondly, the qualitative thematic analysis results are presented pertaining to participants' written reflections from Module 6 and 12 of the SP/SR program.

Quantitative Descriptive Analysis

Adapted Cognitive Therapist Empathy Scale v3.0. Total scores for the adapted CTES v3.0 were calculated by summing the 18 individual item scores. Reverse scoring was used for items 9, 12, and 13 (e.g., an original score of "30" became a score of "70"). The mean was then calculated to provide a total score out of 100, with higher scores indicative of greater empathy. Preliminary data checking was carried out to screen the data set for errors and missing data, however no errors or missing data were detected. Due to the small sample size, the data was not screened for possible outliers.

Table 1 presents the descriptive statistics for the adapted CTES v3.0, gathered at five different data-collection stages pertaining to the participants' SP/SR program. A small increase of 4.1 (4.1%) in the mean total scores was observed between the first and final data-collection points. The mean total scores at the baseline and pre-intervention stages were very similar, with a difference of just 0.03 (0.03%). Likewise, the mean total scores at the post-intervention and follow-up stages showed a difference of just 0.18 (0.18%).

Table 1

Group Descriptive Statistics for the Adapted Cognitive Therapist Empathy Scale v3.0

Data-collection stage	*N*	Range	Min	Max	Mean	*SD*
Baseline	7	33.0	62.2	95.2	75.26	10.81
Pre-intervention	7	31.7	58.8	90.5	75.23	13.76
Midpoint	7	26.4	63.8	90.2	75.77	10.80
Post-intervention	7	21.1	69.1	90.2	79.29	8.79
Follow-up	7	35.3	60.5	95.8	79.47	11.49

Figure 4 shows each participant's total scores (out of 100) for the adapted CTES v3.0 at each of the five data-collection stages. Six of the seven participants showed an increase in total scores at the conclusion of the study, of up to 19.4 (19.4%). Only one participant showed a decrease in total scores.

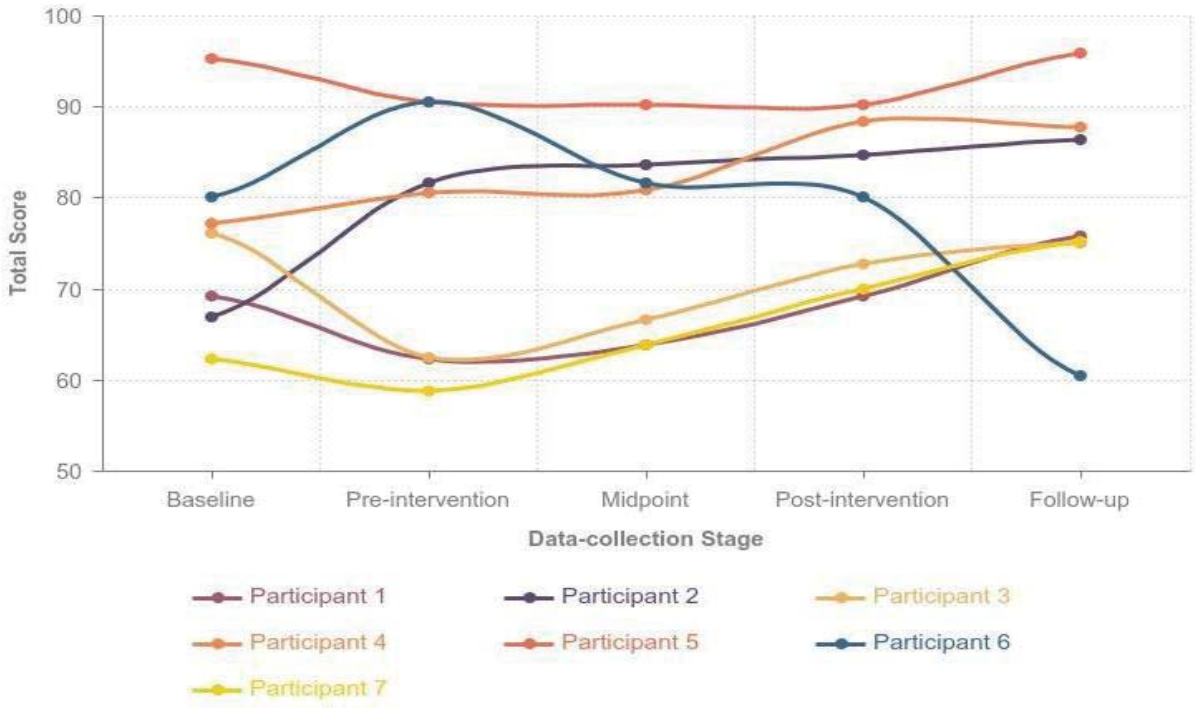

Figure 4. Participant total scores for the adapted Cognitive Therapist Empathy Scale v.3.0.

Adapted Cognitive Therapist Self-Monitoring Scale. Total scores for the adapted CTSMS were calculated by summing the 12 individual item scores. The mean was then calculated to provide a total score out of 100, with higher scores indicative of greater self-monitoring skills. Preliminary data checking was carried out to screen the data set for errors and missing data. No errors were detected, but an individual item score was found to be missing: Participant 6 marked item 11 as *not applicable* (NA) at the pre-intervention stage, rather than giving the item a score out of 100. As a result, Participant 6's mean score was calculated by dividing their total score by 11, not 12. Due to the small sample size, the data was not screened for possible outliers.

Table 2 presents the descriptive statistics for the adapted CTSMS, gathered at five different data-collection stages pertaining to the participants' SP/SR program. A substantial increase of 35.08 (35.08%) in the mean total scores was observed between the first and final data-collection points. The mean total scores at the baseline and pre-intervention stages showed

a difference of 16.5 (16.5%). The mean total scores at the post-intervention and follow-up stages showed a difference of 7.34 (7.34%).

Table 2

Group descriptive Statistics for the Adapted Cognitive Therapist Self-Monitoring Scale

Data-collection stage	*N*	Range	Min	Max	Mean	*SD*
Baseline	7	33.8	21.2	55.0	35.39	12.49
Pre-intervention	7	49.7	27.5	77.2	51.89	17.50
Midpoint	7	45.0	35.0	80.0	58.37	16.93
Post-intervention	7	45.0	35.0	80.0	63.13	17.82
Follow-up	7	38.2	49.1	87.3	70.47	15.31

Figure 5 shows each participant's total scores (out of 100) for the adapted CTSMS at each of the five data-collection stages. All seven participants showed an increase in total scores at the conclusion of the study, of up to 48.7 (48.7%).

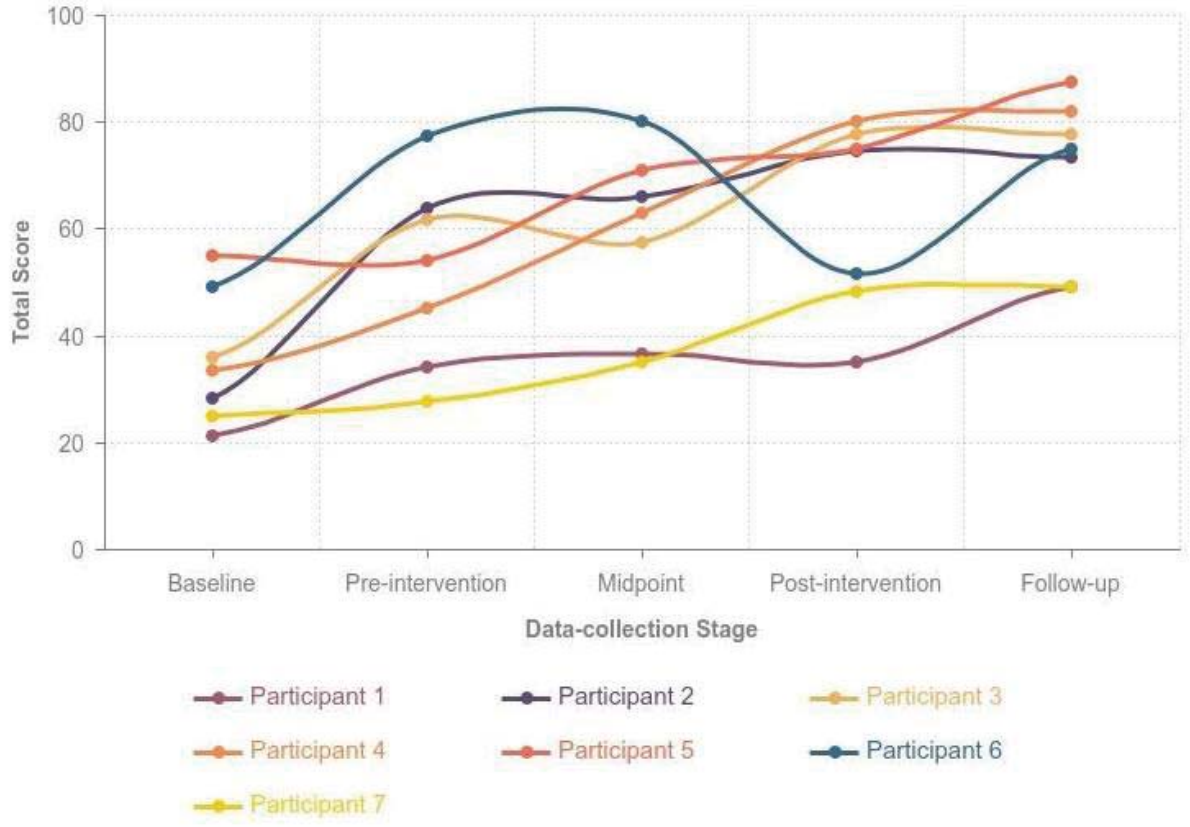

Figure 5. Participant total scores for the adapted Cognitive Therapist Self-Monitoring Scale.

Cognitive Flexibility Inventory. Total scores for the CFI were calculated by summing the 20 individual item scores. The alternatives subscale scores were calculated by summing items 1, 2, 3, 5, 6, 8, 10, 12, 13, 15, 16, 18, and 20. The control subscale scores were calculated by summing items 4, 7, 9, 11, 14, 17, and 19. Reverse scoring was used for items 2, 4, 7, 9, 11, and 17 (e.g., an original score of "2" became a score of "6"). A total score out of 140 was provided, with higher scores indicative of greater cognitive flexibility. Preliminary data checking was carried out to screen the data set for errors and missing data, however no errors or missing data were detected. Due to the small sample size, the data was not screened for possible outliers.

Table 3 presents the descriptive statistics for the CFI, gathered at five different data-collection stages pertaining to the participants' SP/SR program. An increase of 10.42 (7.44%)

in the mean total scores was observed between the first and final data-collection points. The mean total scores at the baseline and pre-intervention stages were very similar, with a difference of just 2.42 (1.73%). Likewise, the mean total scores at the post-intervention and follow-up stages showed a difference of just 2.71 (1.94%).

Table 3

Group descriptive Statistics for the Cognitive Flexibility Inventory

Data-collection stage	*N*	Range	Min	Max	Mean	*SD*
Baseline	7	43	85	128	111.29	15.99
Pre-intervention	7	37	95	132	113.71	12.78
Midpoint	7	31	96	127	116.29	10.83
Post-intervention	7	26	104	130	119.00	10.02
Follow-up	7	21	113	134	121.71	8.36

Figure 6 shows each participant's total scores (out of 140) for the CFI at each of the five data-collection stages. Six of the seven participants showed an increase in total scores at the conclusion of the study, of up to 32 (22.86%). Only one participant showed a decrease in total scores.

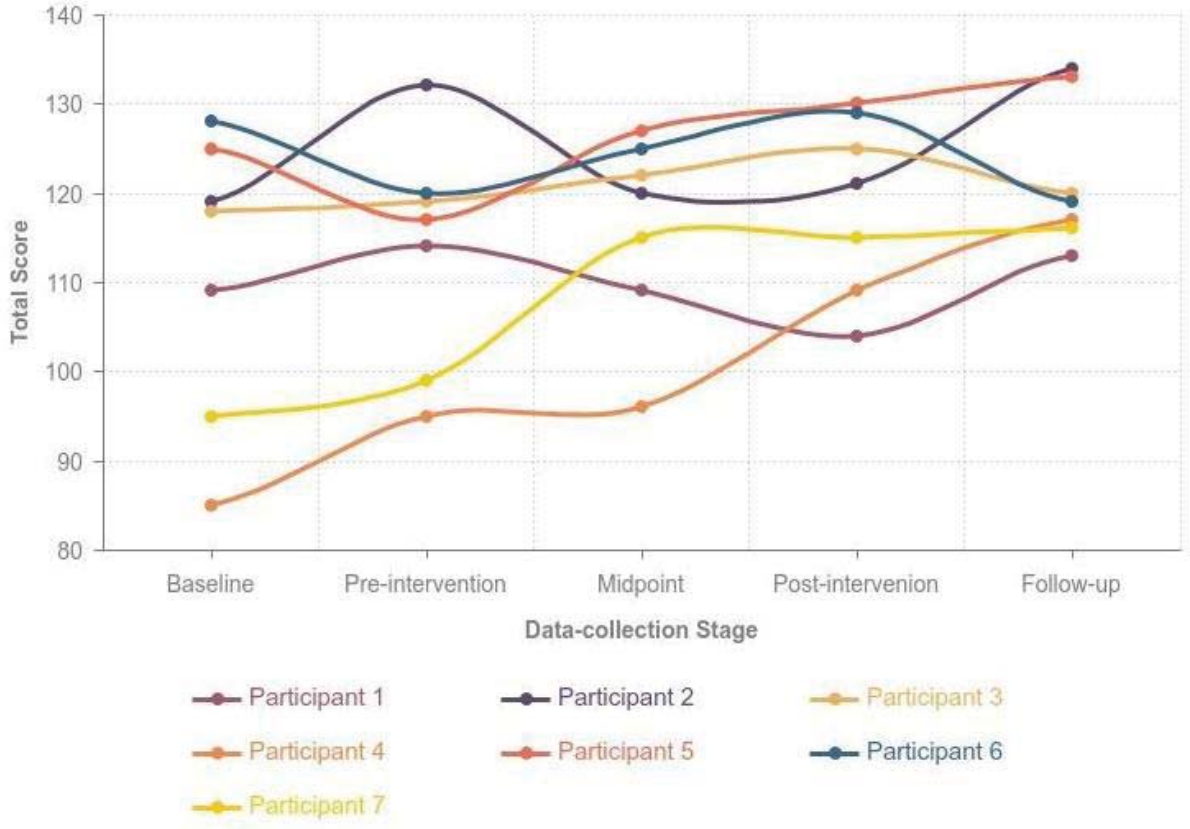

Figure 6. Participant total scores for the Cognitive Flexibility Inventory.

Perceived Stress Scale. Total scores for the PSS were calculated by summing the 10 individual item scores. Reverse scoring was used for items 4, 5, 7, and 8 (e.g., an original score of "4" became a score of "0"). A total score out of 40 was provided, with lower scores indicative of lower perceived stress. Preliminary data checking was carried out to screen the data set for errors and missing data, however no errors or missing data were detected. Due to the small sample size, the data was not screened for possible outliers.

Table 4 presents the descriptive statistics for the PSS, gathered at five different data-collection stages pertaining to the participants' SP/SR program. A decrease of 2.28 (5.7%) in the mean total scores was observed between the first and final data-collection points. The mean total scores at the baseline and pre-intervention stages were very similar, with a difference of

just 0.57 (1.43%). Likewise, the mean total scores at the post-intervention and follow-up stages showed a difference of just 0.86 (2.15%).

Table 4

Group descriptive Statistics for the Perceived Stress Scale

Data-collection stage	*N*	Range	Min	Max	Mean	*SD*
Baseline	7	20	12	32	17.14	7.01
Pre-intervention	7	18	11	29	17.71	5.96
Midpoint	7	13	10	23	16.43	4.86
Post-intervention	7	15	8	23	14.00	6.38
Follow-up	7	13	10	23	14.86	8.08

Figure 7 shows each participant's total scores (out of 40) for the PSS at each of the five data-collection stages. Four of the seven participants showed a decrease in total scores at the conclusion of the study (positively indicating a decrease in perceived stress), of up to 12 (30%). Only one participant showed an increase in total scores at the post-intervention stage (negatively indicating an increase in perceived stress), but three participants showed an increase in total scores at the follow-up stage.

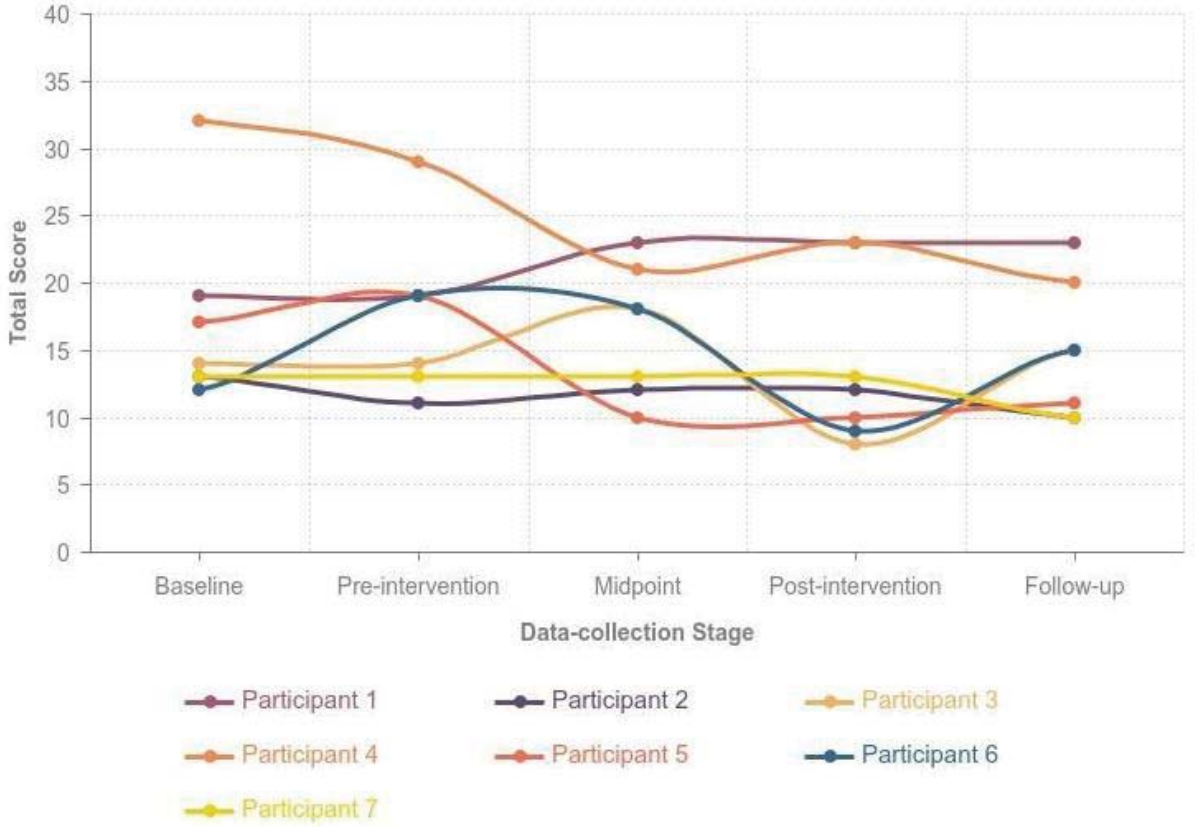

Figure 7. Participant total scores for the Perceived Stress Scale.

Self-Compassion Scale – Short Form. Total scores for the SCS-SF were calculated by summing the 12 individual item scores. The self-kindness subscale scores were calculated by summing items 2 and 6; the self-judgment subscale scores were calculated by summing items 11 and 12; the common humanity subscale scores were calculated by summing items 5 and 10; the isolation subscale scores were calculated by summing items 4 and 8; the mindfulness subscale scores were calculated by summing items 3 and 7; and the over-identification subscale scores were calculated by summing items 1 and 9. The means were then calculated for each subscale to provide 6 subscale scores out of 5. When calculating total self-compassion scores, reverse scoring was used for items 1, 4, 8, 9, 11, and 12 (e.g., an original score of "1" became a score of "5"). The mean was then calculated to provide a total score out of 5, with higher scores indicative of greater self-compassion. Preliminary data checking was carried out to

screen the data set for errors and missing data, however no errors or missing data were detected. Due to the small sample size, the data was not screened for possible outliers.

Table 5 presents the descriptive statistics for the SCS-SF, gathered at five different data-collection stages pertaining to the participants' SP/SR program. An increase of 0.53 (10.6%) in the mean total scores was observed between the first and final data-collection points. The mean total scores at the baseline and pre-intervention stages showed a difference of 0.23 (4.6%). The mean scores at the post-intervention and follow-up stages showed a difference of 0.21 (4.2%).

Table 5

Group descriptive Statistics for the Self-Compassion Scale – Short Form

Data-collection stage	*N*	Range	Min	Max	Mean	*SD*
Baseline	7	43	2.4	4.7	3.46	0.82
Pre-intervention	7	37	2.5	4.9	3.69	0.85
Midpoint	7	31	2.8	4.8	3.64	0.85
Post-intervention	7	26	2.9	4.8	3.78	0.77
Follow-up	7	21	3.3	4.9	3.99	0.71

Figure 8 shows each participant's total scores (out of 5) for the SCS-SF at each of the five data-collection stages. All seven participants showed an increase in total scores at the conclusion of the study, of up to 1.0 (20%).

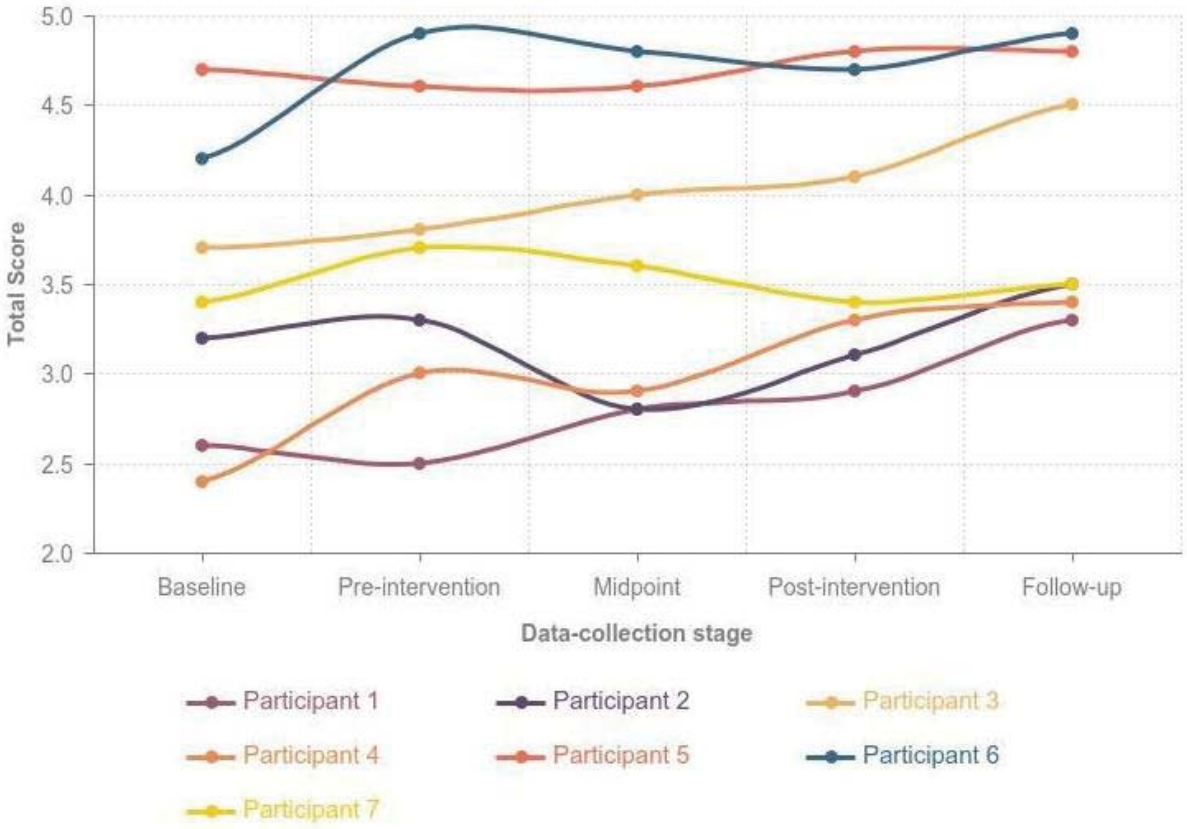

Figure 8. Participant total scores for the Self-Compassion Scale – Short Form.

Self-Reflection and Insight Scale. Total scores for the SRIS were calculated by summing the 20 individual item scores. The engagement in self-reflection subscale scores were calculated by summing items 1, 8, 10, 13, 16, and 19; the need for self-reflection subscale scores were calculated by summing items 2, 5, 7, 12, 15, and 18; and the insight subscale scores were calculated by summing items 3, 4, 6, 9, 11, 14, 17, and 20. Reverse scoring was used for items 1, 2, 4, 8, 9, 11, 14, and 17 (e.g., an original score of "2" would become a score of "5"). A total score out of 120 was provided, with higher scores indicative of greater self-reflection and insight. Preliminary data checking was carried out to screen the data set for errors and missing data. No errors were detected, but an individual item score was found to be missing: Participant 5 left item 11 blank at the pre-intervention stage, rather than circling a number between 1 – 6. No indication was given as to why the item was left blank. As a result,

Participant 5's total score at the pre-intervention stage includes a deficit of between 0.83 and 5 percent. Due to the small sample size, the data was not screened for possible outliers.

Table 6 presents the descriptive statistics for the SRIS, gathered at five different data-collection stages pertaining to the participants' SP/SR program. An increase of 3.57 (2.98%) in the mean total scores was observed between the first and final data-collection points. The mean total scores at the baseline and pre-intervention stages showed a difference of 4.72 (3.93%). The mean total scores at the post-intervention and follow-up stages were very similar, with a difference of just 1.43 (1.19%).

Table 6

Group descriptive Statistics for the Self-Reflection and Insight Scale

Data-collection stage	*N*	Range	Min	Max	Mean	*SD*
Baseline	7	43	73	114	91.43	13.64
Pre-intervention	7	37	77	103	86.71	11.27
Midpoint	7	31	75	113	90.86	12.23
Post-intervention	7	26	86	114	96.43	9.33
Follow-up	7	21	85	107	95.00	8.70

Figure 9 shows each participant's total scores (out of 120) for the SRIS at each of the five data-collection stages. Four of the seven participants showed an increase in total scores at the conclusion of the study, of up to 13 (10.83%). Only one participant showed a decrease in total scores at the post-intervention stage, but three participants showed a decrease in total scores at the follow-up stage.

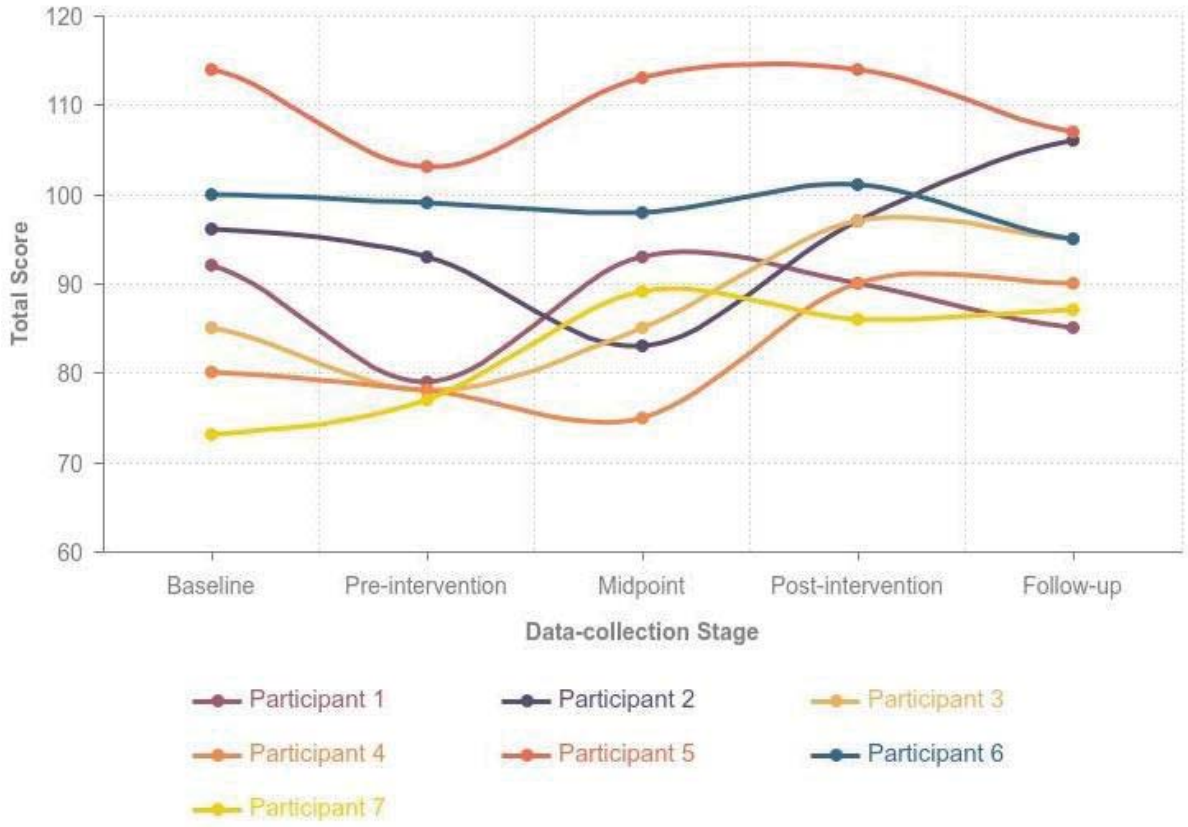

Figure 9. Participant total scores for the Self-Reflection and Insight Scale.

Individual case study: Participant 1. Figure 10 shows Participant 1's scores for all six measures at each of the five data-collection stages. As for each individual case study, all scores have been converted into percentages to allow for comparison between measures. An increase in total scores between the first and final data-collection stages was observed for five of the six measures; 6.6% (6.6 out of 100) for the adapted CTES v3.0; 27.9% (27.9 out of 100) for the adapted CTSMS; 2.89% (4 out of 140) for the CFI; 14% (0.7 out of 5) for the SCS-SF; and 10% (4 out of 40) for the PSS (negatively indicating an increase in perceived stress). A decrease of 5.83% (7 out of 120) in total scores between the first and final data-collection stages was observed for the SRIS. However, when the pre- and post-intervention scores were compared for this measure, an increase of 9.17% (11 out of 120) was observed.

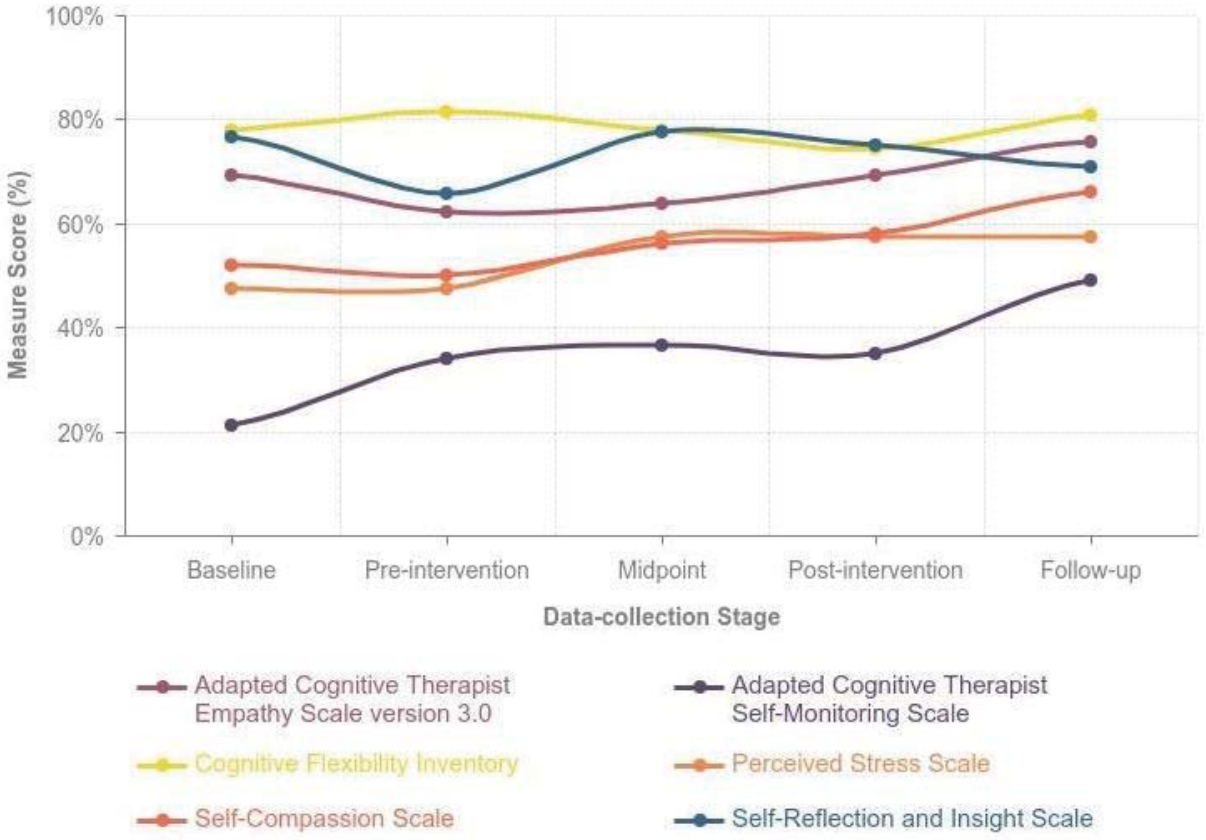

Figure 10. Participant 1's measure scores for the adapted Cognitive Therapist Empathy Scale v.3.0, adapted Cognitive Therapist Self-Monitoring Scale, Cognitive Flexibility Inventory, Perceived Stress Scale, Self-Compassion Scale – Short Form, and Self-Reflection and Insight Scale.

Individual case study: Participant 2. Figure 11 shows Participant 2's scores for all six measures at each of the five data-collection stages. An increase in total scores between the first and final data-collection stages was observed for five of the six measures; 19.4% (19.4 out of 100) for the adapted CTES v3.0; 45% (45 out of 100) for the adapted CTSMS; 10.71% (15 out of 140) for the CFI; 6% (0.3 out of 5) for the SCS-SF; and 8.33% (10 out of 120) for the SRIS. A decrease of 7.5% (3 out of 40) in total scores between the first and final data-collection stages was observed for the PSS (positively indicating a decrease in perceived stress).

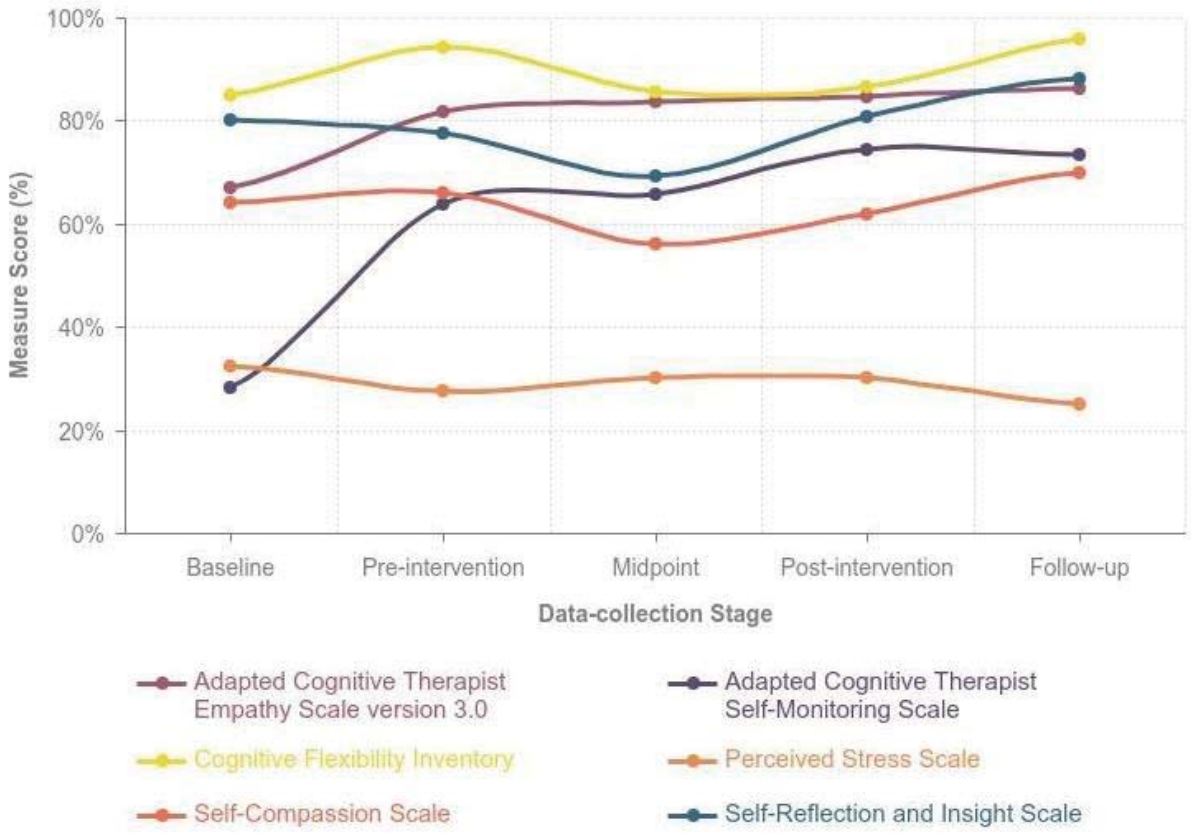

Figure 11. Participant 2's measure scores for the adapted Cognitive Therapist Empathy Scale v.3.0, adapted Cognitive Therapist Self-Monitoring Scale, Cognitive Flexibility Inventory, Perceived Stress Scale, Self-Compassion Scale – Short Form, and Self-Reflection and Insight Scale.

Individual case study: Participant 3. Figure 12 shows Participant 3's scores for all six measures at each of the five data-collection stages. An increase in total scores between the first and final data-collection stages was observed for five of the six measures; 41.7% (41.7 out of 100) for the adapted CTSMS; 1.43% (2 out of 140) for the CFI; 16% (0.8 out of 5) for the SCS-SF; 8.33% (10 out of 120) for the SRIS; and 2.5% (1 out of 40) for the PSS (negatively indicating an increase in perceived stress). However, when the pre- and post-intervention scores were compared for the PSS, a decrease of 15% (6 out of 40) was observed (positively indicating a decrease in perceived stress). A decrease of 1.1% (1.1 out of 100) in total scores

between the first and final data-collection stages was observed for the adapted CTES v3.0. However, when the pre- and post-intervention scores were compared for this measure, an increase of 12.5% (12.5 out of 100) was observed.

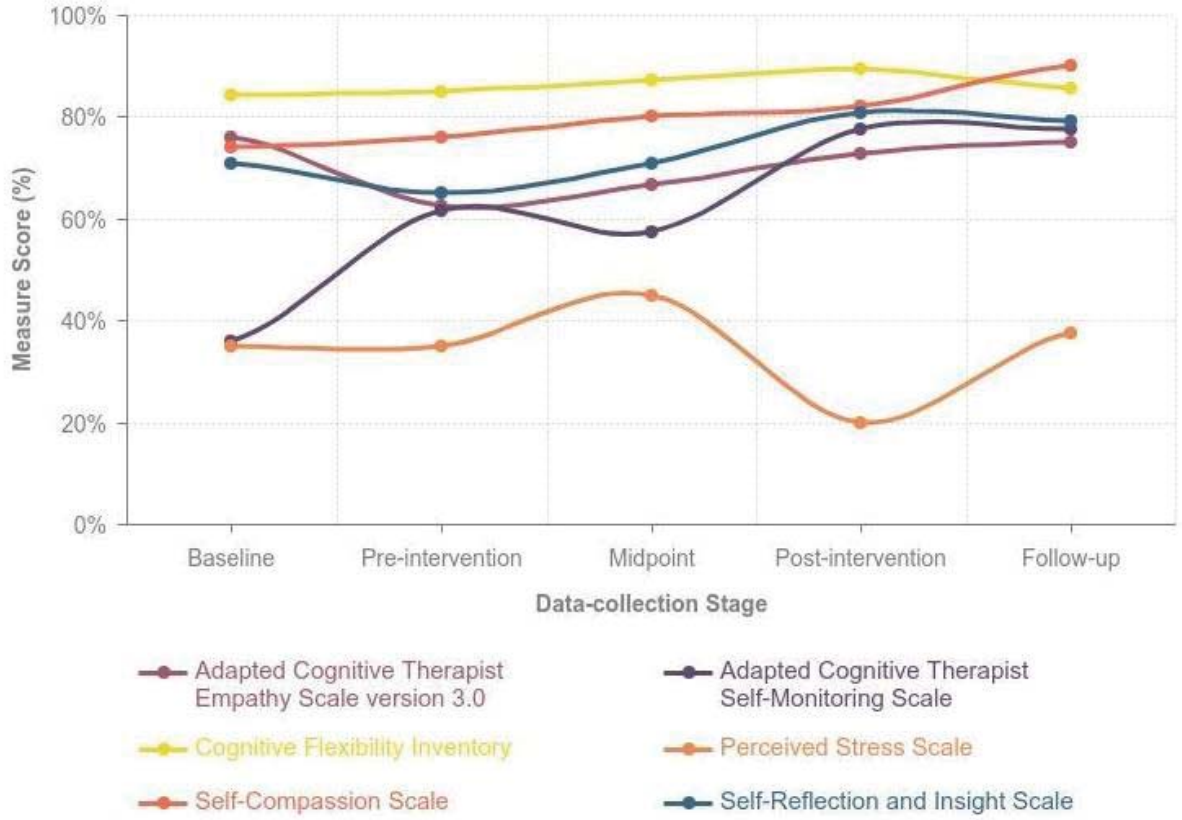

Figure 12. Participant 3's measure scores for the adapted Cognitive Therapist Empathy Scale v.3.0, adapted Cognitive Therapist Self-Monitoring Scale, Cognitive Flexibility Inventory, Perceived Stress Scale, Self-Compassion Scale – Short Form, and Self-Reflection and Insight Scale.

Individual case study: Participant 4. Figure 13 shows Participant 4's scores for all six measures at each of the five data-collection stages. An increase in total scores between the first and final data-collection stages was observed for five of the six measures; 10.5% (10.5 out of 100) for the adapted CTES v3.0; 48.7% (48.7 out of 100) for the adapted CTSMS; 22.86% (32 out of 140) for the CFI; 20% (1 out of 5) for the SCS-SF; and 8.33% (10 out of 120) for the

SRIS. A decrease of 30% (12 out of 40) in total scores between the first and final data-collection stages was observed for the PSS (positively indicating a decrease in perceived stress).

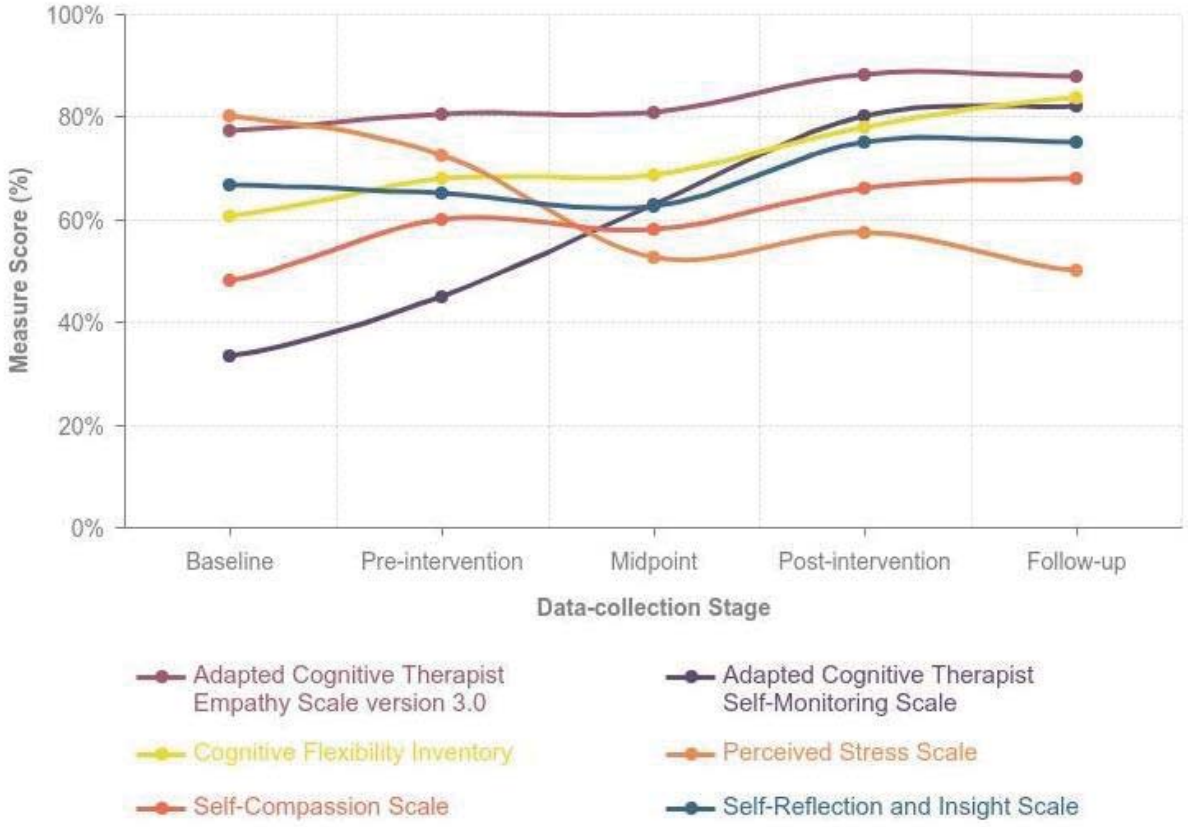

Figure 13. Participant 4's measure scores for the adapted Cognitive Therapist Empathy Scale v.3.0, adapted Cognitive Therapist Self-Monitoring Scale, Cognitive Flexibility Inventory, Perceived Stress Scale, Self-Compassion Scale – Short Form, and Self-Reflection and Insight Scale.

Individual case study: Participant 5. Figure 14 shows Participant 5's scores for all six measures at each of the five data-collection stages. An increase in total scores between the first and final data-collection stages was observed for four of the six measures; 0.6% (0.6 out of 100) for the adapted CTES v3.0; 32.3% (32.3 out of 100) for the adapted CTSMS; 5.71% (8 out of 140) for the CFI; and 2% (0.1 out of 5) for the SCS-SF. A decrease of 15% (6 out of 40) in total scores between the first and final data-collection stages was observed for the PSS

(positively indicating a decrease in perceived stress). A decrease of 5.83% (7 out of 120) in total scores between the first and final data-collection stages was observed for the SRIS. However, when the pre- and post-intervention scores were compared for this measure, an increase of 9.17% (11 out of 120) was observed.

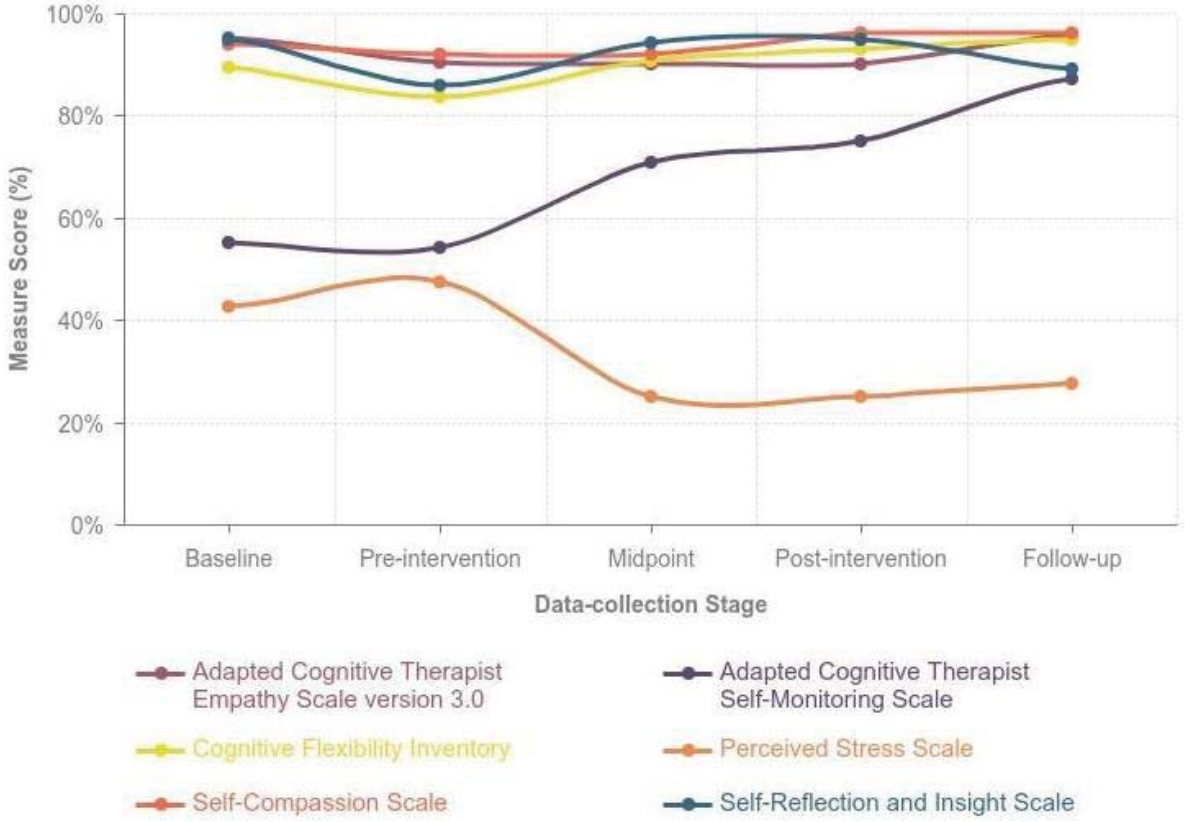

Figure 14. Participant 5's measure scores for the adapted Cognitive Therapist Empathy Scale v.3.0, adapted Cognitive Therapist Self-Monitoring Scale, Cognitive Flexibility Inventory, Perceived Stress Scale, Self-Compassion Scale – Short Form, and Self-Reflection and Insight Scale.

Individual case study: Participant 6. Figure 15 shows Participant 6's scores for all six measures at each of the five data-collection stages. An increase in total scores between the first and final data-collection stages was observed for three of the six measures; 28.1% (28.1 out of 100) for the adapted CTSMS; 14% (0.7 out of 5) for the SCS-SF; and 7.5% (3 out of 40) for

the PSS (negatively indicating an increase in perceived stress). However, when the pre- and post-intervention scores were compared for the PSS, a decrease of 25% (10 out of 40) was observed (positively indicating a decrease in perceived stress). A decrease of 19.5% (19.5 out of 100) was observed between the first and final data-collection stages for the adapted CTES v3.0. A decrease of 6.43% (9 out of 140) in total scores between the first and final data-collection stages was observed for the CFI. However, when the pre- and post-intervention scores were compared for this measure, an increase of 6.43% (9 out of 140) was observed. A decrease of 5% (6 out of 120) was observed between the first and final data-collection stages for the SRIS. However, when the pre- and post-intervention scores were compared for this measure, an increase of 7.5% (9 out of 120) was observed.

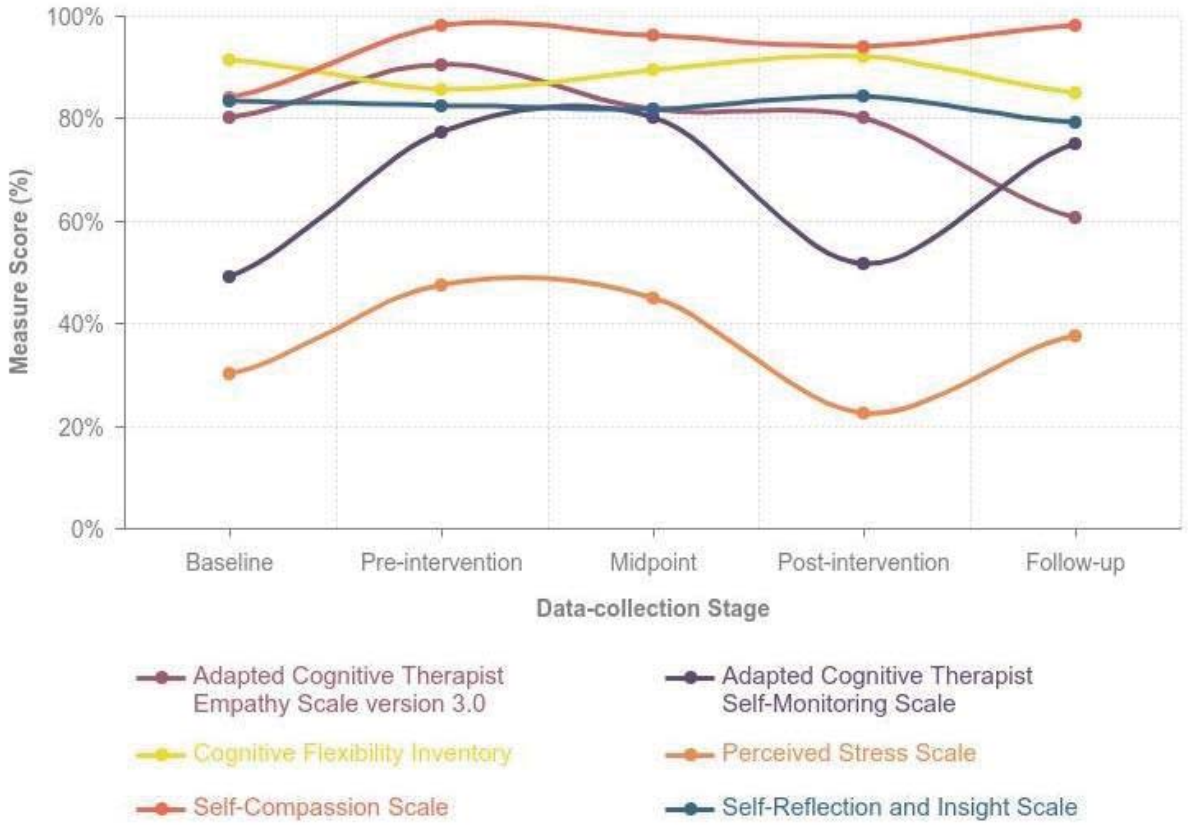

Figure 15. Participant 6's measure scores for the adapted Cognitive Therapist Empathy Scale v.3.0, adapted Cognitive Therapist Self-Monitoring Scale, Cognitive Flexibility Inventory,

Perceived Stress Scale, Self-Compassion Scale – Short Form, and Self-Reflection and Insight Scale.

Individual case study: Participant 7. Figure 16 shows Participant 7's scores for all six measures at each of the five data-collection stages. An increase in total scores between the first and final data-collection stages was observed for five of the six measures; 13% (13 out of 100) for the adapted CTES v3.0; 24.1% (24.1 out of 100) for the adapted CTSMS; 15% (21 out of 140) for the CFI; 11.67% (14 out of 120) for the SRIS; and 2% (0.1 out of 5) for the SCS-SF. However, it is worth noting that a greater increase of 6% (0.3 out of 5) was observed for the SCS-SF when the pre- and post-intervention scores were compared. A decrease of 7.5% (3 out of 40) in total scores between the first and final data-collection stages was observed for the PSS (positively indicating a decrease in perceived stress).

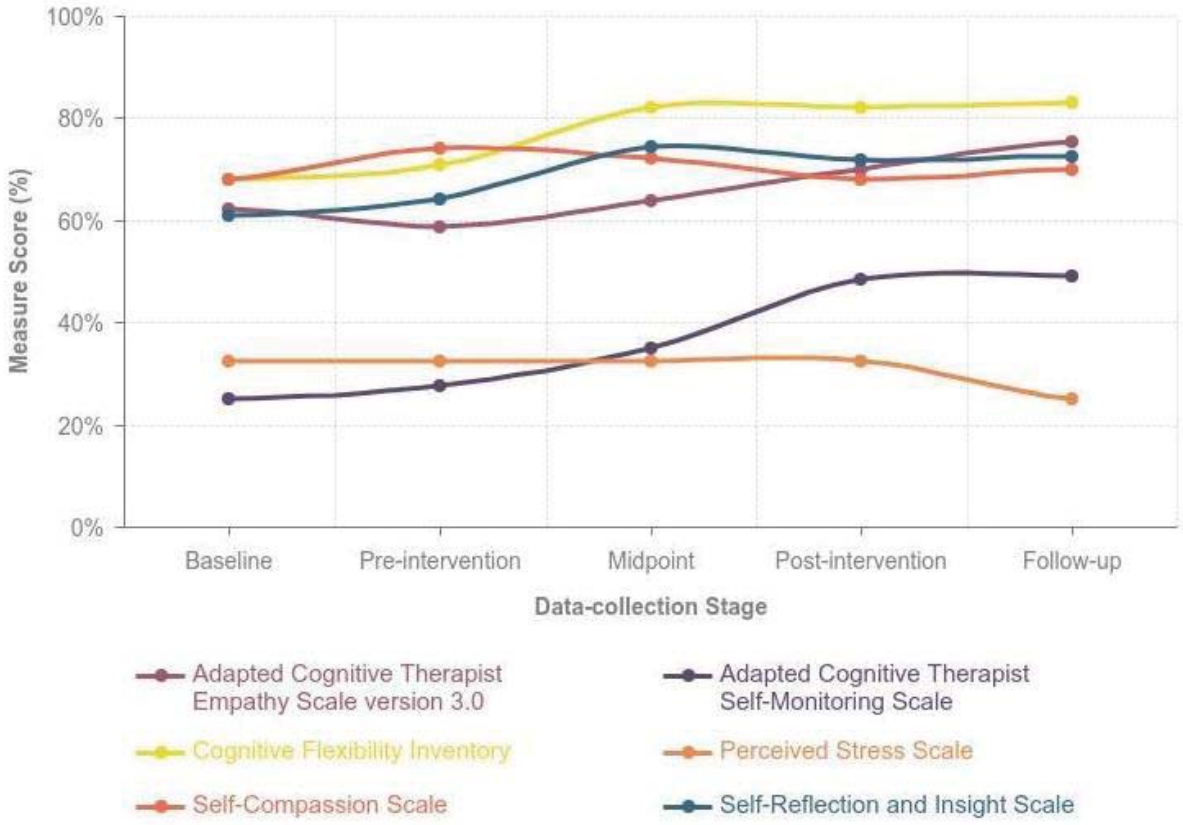

Figure 16. Participant 7's measure scores for the adapted Cognitive Therapist Empathy Scale v.3.0, adapted Cognitive Therapist Self-Monitoring Scale, Cognitive Flexibility Inventory,

Perceived Stress Scale, Self-Compassion Scale – Short Form, and Self-Reflection and Insight Scale.

Qualitative Thematic Analysis

Thematic analysis of the qualitative data identified five primary themes pertaining to participants' experience of the SP/SR program: enhanced empathy; the importance of collaboration; the development of helpful tools to address problems; time constraints as a potential barrier; and an overall positive impact on personal and professional development. This section will describe and provide relevant examples from within the data set for each of the themes identified. It is worth noting that quotes are presented according to participants' written self-reflections regardless of spelling or grammar, in order to maintain research integrity.

Theme 1: Enhanced empathy. Participants unanimously reported that the SP/SR program enhanced their empathy toward clients. The primary way this was expressed was in reports of gaining a deeper understanding of what therapy is like for clients and, more specifically, what CBT is like for clients. Many participants also drew a connection between their enhanced empathy and clinical practice. This is illustrated by the following comments:

> *"I feel by engaging in this process it has enhanced my practice as I have a better understanding of what I am asking clients to do that I am also prepared to do the task with them if required or to problem solve difficulties in engaging in the task." (Participant 1; Module 12).*

> *"Through doing this it has given me an experience of how doing CBT can be for our clients and some of the problems that can come up and how to ensure the goals we are setting our clients are achievable." (Participant 2; Module 12).*

> *"[SP/SR] provides me with insight to the difficulties my clients might also experience. This has the added benefit of helping to reassure my clients that I do understand how difficult it can be which should only enhance and strengthen the therapeutic relationship in my opinion." (Participant 4; Module 12).*

Theme 2: The importance of collaboration. Many participants reported that their experience of SP/SR highlighted the importance of collaboration between them (as therapists) and their clients. This was summarised by the following participants:

> *"Realising the value and importance of my own Maintenance Plan underlined the importance of ensuring that a Relapse Plan is completed collaboratively with my therapy clients in the future." (Participant 3; Module 12).*

> *"From a professional perspective, the important "take-home" messages from this workbook [include] the importance of collaboration when working with clients…" (Participant 3; Module 12).*

> *"With regard to client work, I do have a few clients who have some of the same tendencies that I do and it has helped me to see … how important it is to collaboratively look at the obstacles to progress and problem-solving around those." (Participant 7; Module 6).*

Theme 3: The development of helpful tools to address problems. As a result of their participation in the SP/SR program, participants unanimously reported developing tools that may be used to address personal and/or professional problems in their own lives. For example:

> *"The SP has been extremely useful in learning more about various tools and their nuances, but the work holds a great deal more benefit when followed by SR." (Participant 5; Module 6).*

"I have really enjoyed doing the exercises as it have given my current reflective practice an even broader range of tools that I can use." (Participant 2; Module 6).

"With the self-practice, I particularly liked doing the activity schedule. I learned so much more about it. I am presently benefiting from doing an activity schedule." (Participant 3; Module 6).

"From this module I have decided to get more balance in my life. I need to look at implementing an activity schedule to include work related issues, study and pleasure so that I am able to find balance and elevate my stress/feelings of being overwhelmed." (Participant 1; Module 6).

"It has been good learning cognitive strategies for changing the way I think and doing behavioural experiments has given me the opportunity to test out my thoughts." (Participant 2; Module 12).

In addition, many participants expressed a belief that these tools would also be useful when dealing with clients. It is worth noting that the "tools" referred to by participants were not necessarily specific CBT tools or techniques, but included other benefits experienced such as a change in perspective. An example of this is illustrated by the following participant:

"Being able to take a moment to sit back, think about what is happening and to listen to my clients without necessarily having all the answers has become a powerful tool for me to use in my practice." (Participant 4; Module 6).

Theme 4: Time constraints as a potential barrier. Many participants acknowledged time constraints as the primary difficulty encountered when completing the SP/SR program. However, the benefits of SP/SR were commonly cited as a motivator to overcome this potential barrier (both during the program and when continuing with SP/SR in the future). For example:

> *"Time management was one of the main roadblocks [to SP/SR]." (Participant 3; Module 6).*

> *"The self reflection that is part of the SP/SR process is probably the hardest part as it requires … time – and that can be hard to find. But without doing the reflection the learning would be quite superficial." (Participant 7; Module 6).*

> *"Finding time to complete the modules has been the most difficult part of completing the SP/SR workbook. In the future I will need to ensure that this becomes a priority for me, and managing my time more effectively needs to occur so as to not fall behind. I am confident that I will be able to do this as I can see now how beneficial the process is both personally and clinically." (Participant 4; Module 12).*

In addition, the experience of completing the SP/SR exercises while under time constraints was acknowledged as a meaningful contributor to better understanding how clients may feel when completing similar exercises as part of their therapy. This is summarised by the following participant:

> *"Knowing that I am ½ way through the workbook [provides] a sense of relief because I have had so much else on my plate …. Having said this, every one of the modules has been beneficial and added to my personal and professional insight. This will be important to keep in mind when working with busy/overwhelmed/resistant clients." (Participant 5; Module 6).*

Theme 5: Positive impact on personal and professional development. Participants unanimously reported that engagement in SP/SR had a positive impact on their personal and professional development, despite the fact that some participants' scores decreased for one or more of the quantitative measures. This is illustrated by all 7 participants:

"I feel by engaging in this process it has enhanced my practice as I have a better understanding of what I am asking clients to do …. Personally I have also gained a lot. I definitely will continue SP/SR as this will enhance my practice further." (Participant 1; Module 12).

"I felt happy and excited by what I had achieved as I hadn't thought the amount of time I had been able to give a week to doing this would bring about so much change. I envisage continuing with SP/SR in the future." (Participant 2; Module 12).

"Doing SP/SR will have positive impact in my practice as well as my personal life." (Participant 3; Module 6).

"Noticeably I have seen a change in myself personally and also professionally …." (Participant 4; Module 6).

"…every one of the modules has been beneficial and added to my personal and professional insight." (Participant 5; Module 6).

"…I have learnt more about the things than enhance wellbeing, communication and generally make life a little easier as well as learning about the things which I thought worked but in reality don't do much for me. I liked going from the problem to new ways of being, it helped me to develop new ways of being." (Participant 6; Module 12).

"I think SP/SR has been useful for both my personal self but also for my professional self as it has given me greater insight and has helped to stop being as self-critical as I had been." (Participant 7; Module 6).

Summary

Overall, the quantitative data and subsequent analysis provides valuable insight that is unique to SP/SR literature. The results allow the researcher to gain a clearer understanding of

how SP/SR effects six specific dimensions of therapist competence: empathy, cognitive flexibility, insight, self-compassion, self-monitoring, and stress. The qualitative data provides valuable context for these findings, particularly in terms of the participants' experience of SP/SR, whilst simultaneously creating an opportunity to identify further effects of SP/SR beyond the scope of this study (e.g., therapist-client collaboration). This information may be used to refine future CBT training strategies, particularly in reference to the use of SP/SR in developing therapist competence. A discussion of these findings will be covered in the following chapter.

Discussion

Overview

Despite the growing SP/SR literature, research is yet to sufficiently determine the full extent to which SP/SR impacts CBT therapist development, and research regarding its impact on specific therapist skills and competence is particularly lacking. In light of this, the current study aimed to explore the effects of SP/SR on six specific dimensions of CBT therapist competence: cognitive flexibility, empathy, insight, self-compassion, self-monitoring, and stress, among postgraduate CBT trainees completing a SP/SR program as part of their training. This chapter begins by presenting a summary of the current research findings. The findings are then discussed regarding each dimension of CBT therapist competence in turn (e.g., "Self-Practice/Self-Reflection and Cognitive Flexibility"), in the context of both the study aims and current literature. The relevance and potential interpretations of the individual case studies are also discussed, in addition to the qualitative thematic analysis results. Following this, limitations of the current research are considered, before implications and suggestions for future research are presented.

Summary of Findings

Scores for the adapted CTES v.3.0 improved for five out of seven participants between the first and final data-collection stages, with a mean score increase of 10.02% and a highest score increase of 19.4%. Scores for the adapted CTSMS improved for all seven participants, with a mean score increase of 35.08% and a highest score increase of 48.7%. Scores for the CFI improved for six out of seven participants, with a mean score increase of 9.77% and a highest score increase of 22.86%. Scores for the PSS improved for four out of seven participants, with a mean score decrease of 15% and a highest score decrease of 30%. However, it is worth noting that at the post-intervention stage, scores for six out of seven participants had

improved. Scores for the SCS-SF improved for all seven participants, with a mean increase of 10.6% and a highest score increase of 20%. Scores for the SRIS improved for four out of seven participants, with a mean score increase of 9.17% and a highest score increase of 11.67%. However, again it is worth noting that at the post-intervention stage, scores for all seven participants had improved.

Three out of seven participants' scores improved for all six measures between the first and final data-collection stages: Participant 2, Participant 4, and Participant 7. Participant 1's scores improved for four out of six measures: the adapted CTES v3.0, adapted CTSMS, CFI, and SCS-SF. Scores worsened for the PSS and the SRIS. However, when the pre- and post-intervention scores were compared, an improvement was also observed for the SRIS. Participant 3's scores also improved for four out of six measures: the adapted CTSMS, CFI, SCS-SF, and SRIS. Scores worsened for the adapted CTES v3.0 and the PSS. However, when the pre- and post-intervention scores were compared, an improvement was also observed for these two measures. Participant 5's scores improved for five out of six measures: the adapted CTES v3.0, adapted CTSMS, CFI, SCS-SF, and PSS. Scores worsened for the SRIS. However, when the pre- and post- intervention scores were compared, an improvement was also observed for this measure. Participant 6's scores improved for two out of six measures: the adapted CTSMS and SCS-SF. Scores worsened for the adapted CTES v3.0, CFI, PSS, and SRIS. However, when the pre- and post- intervention scores were compared, an improvement was observed for all measures excepted the adapted CFES v3.0.

In addition to the quantitative findings, thematic analysis of the qualitative data identified 5 primary themes regarding the participants' experience of SP/SR. These themes included: (1) enhanced empathy, (2) the importance of collaboration, (3) the development of helpful tools to address problems, (4) time constraints as a potential barrier, and (5) an overall positive impact on personal and professional development.

Self-Practice/Self-Reflection and Cognitive Flexibility

Scores for the CFI improved for six out of seven participants, with a mean increase of 9.77% between the baseline and follow-up stages ($n = 6$). Improvements varied in significance, ranging from 1.43% - 22.86% during this timeframe. It is worth noting that the mean score at baseline was 79.49%, leaving very limited room for improvement (20.51%). Although a decrease of 6.43% was observed for Participant 6 between the baseline and follow-up stages, an increase of 6.43% was observed when the pre- and post-intervention scores were compared. One possible explanation for the decrease in Participant 6's scores between the baseline and pre-intervention stages, is initial over-rating (which will be discussed later in this chapter). Furthermore, the decrease in scores between the post-intervention and follow-up stages could potentially be due to drop-off effects: Participant 6 demonstrated enhanced cognitive flexibility between the pre- and post-intervention stages, but these results did not appear to be sustained once the SP/SR program had concluded. All in all, these findings suggest that SP/SR may enhance the cognitive flexibility skills of CBT trainees, and provide quantitative support to Bennett-Levy et al.'s (2003) findings outlined in chapter one.

Furthermore, visual inspection of the CFI data revealed that items given a low score of 1 or 2 (out of 7) at baseline did not demonstrate improvement by the conclusion of the SP/SR program (with one exception: Participant 3 scored item 9 as 2 at baseline, and 6 at the follow-up stage). The only items that received improved scores by the post-intervention and/or follow-up stages were rated 3 or above at baseline. In addition, Participant 4 only rated items at a 5 or above (out of 7) at baseline and saw the most consistent increase in total scores at each data-collection point. Thus, the SP/SR program appeared to enhance the aspects of cognitive flexibility that participants were already relatively competent and/or confident in. This suggests that SP/SR may work to consolidate existing cognitive flexibility skills as opposed to developing new ones. This finding can be related back to the DPR model of therapist skill

development (see Figure 1): it provides support for the use of reflection to facilitate ongoing skill development, while highlighting the need for declarative and procedural knowledge systems for initial skill development (Bennett-Levy, 2006).

Self-Practice/Self-Reflection and Empathy

Scores for the CTES v.3.0 improved for five out of seven participants, with a mean increase of 10.02% between the baseline and follow-up stages (n = 5). Improvements varied in significance, ranging from 0.6% - 19.4% during this timeframe. Again, it is worth noting that the mean score at baseline was 75.3%, leaving very limited room for improvement (24.7%). Although a decrease of 1.1% was observed for Participant 3 between the baseline and follow-up stages, an increase of 12.5% was observed when the pre-intervention and follow-up scores were compared. Participant 3's score dropped significantly (13.6%) between the baseline and pre-intervention stages. One possible explanation for this decrease is unfamiliarity with the CTES v.3.0: it is possible that when Participant 3 completed the measure a second time (at the pre-intervention stage), they had a better understanding of how it worked and thus provided more accurate scores than those given at baseline. A significant decrease of 19.5% was observed for Participant 6. This could potentially be explained by enhanced self-awareness resulting from engagement in the SP/SR program, and thus the development of a more realistic view of their empathic skill. In addition, the qualitative thematic analysis of participant reflections revealed that all seven participants reported enhanced empathy as a result of SP/SR. All in all, these findings are consistent with the current literature (e.g., Bennett-Levy et al., 2001; Bennett-Levy et al., 2003; Davis, 2008; Gale & Shroder, 2014; Davis et al., 2014), and provide quantitative support for the use of SP/SR to enhance the empathic skills of CBT trainees.

Furthermore, visual inspection of the CTES v.3.0 data revealed significant score increases for item 8: “I have been able to create a sense of effective collaboration and ‘we-ness’ between myself and my client(s)”. This suggests that therapist-client collaboration may be a specific skill enhanced by SP/SR, and is supported by the qualitative thematic analysis findings: many participants acknowledged a positive impact of SP/SR on collaboration with clients. Substantial score increases were also observed for item 16: “My knowledge of the CBT model has allowed me to help my client(s) make sense of the way that they are feeling”. One possible explanation for this substantial increase is that engaging in CBT exercises (as part of the SP/SR program) enhanced participants’ understanding of the CBT model, which was then utilised in therapy. Again, this finding can be related back to the DPR model of therapist skill development (see Figure 1): it provides further support for the use of reflection in enhancing procedural skills, and suggests that empathy may facilitate this process. These findings identify collaboration and CBT knowledge as important components of empathy that may be especially effected by SP/SR.

Self-Practice/Self-Reflection and Insight

Scores for the SRIS improved for four out of seven participants, with a mean increase of 9.17% between the baseline and follow-up stages (n = 4). Improvements varied in significance, ranging from 8.33% - 11.67% during this timeframe. Again, it is worth noting that the mean score at baseline was 76.2%, leaving very limited room for improvement (23.8%). Although a decrease was observed for Participant 1 (5.83%), Participant 5 (5.83%), and Participant 6 (5%) between the baseline and follow-up stages, an increase was observed for these participants when the pre-intervention and follow-up scores were compared. Scores dropped significantly for Participant 1 (10.83%) and Participant 5 (9.16%) between the baseline and pre-intervention stages. One possible explanation for this decrease is unfamiliarity with the SRIS: it is possible (as mentioned earlier with the CTES v.3.0) that when Participant

1 and 5 completed the measure a second time (at the pre-intervention stage), they had a better understanding of how it worked and thus provided more accurate scores than those recorded at baseline. All in all, these findings suggest that SP/SR may enhance the insight skills of CBT trainees and, consequently, facilitate the ongoing development of CBT therapist competence (Bennett-Levy et al., 2003). Furthermore, these findings provide quantitative support consistent with current literature (e.g., Bennett-Levy et al., 2003).

Self-Practice/Self-Reflection and Self-Compassion

Scores for the SCS-SF improved for all seven participants, with a mean increase of 10.6% between the baseline and follow-up stages (n = 7). Improvements varied in significance, ranging from 2% - 20% during this timeframe. Again, it is worth noting that the mean score at baseline was 69.2%, leaving limited room for improvement (30.8%). In addition, the qualitative thematic analysis of participant reflections revealed that participants unanimously reported a positive impact on their personal development as a result of SP/SR. All in all, these findings suggest that SP/SR may enhance the self-compassion skills of CBT trainees, and provide both quantitative and qualitative evidence for the use of SP/SR to enhance therapist self-care (as suggested by Haarhoff & Thwaites, 2016) and consequently reduce the many physical and/or psychological problems associated with therapist stress (Tyler & Cushway, 1998; Kottler, 2012; Haarhoff & Thwaites, 2016).

Self-Practice/Self-Reflection and Self-Monitoring

Scores for the CTSMS improved for all 7 participants, with a substantial mean increase of 35.08% between the baseline and follow-up stages (n = 7). Improvements varied in significance, ranging from 24.1% - 48.7% during this timeframe. It is worth noting that the mean score at baseline was 35.39%, leaving significantly more room for improvement (64.61%) when compared to the other measures. These findings suggest that SP/SR may

effectively enhance the self-monitoring skills (or self-awareness) of CBT trainees, and thus facilitate the ongoing development of CBT therapist competence (Bennett-Levy et al., 2001). In addition, these findings provide substantial quantitative support for prior research (e.g., Bennett-Levy et al., 2003; Haarhoff et al., 2011).

An interesting distinction can be made between the CTSMS and the other measures used in the study: the CTSMS does not use personal pronouns. Personal pronouns are used in all five of the other measures, such as "I try to see my failings as part of the human condition" (SCS-SF). The CTES v.3.0 uses the same 100-point rating scale as the CTSMS, however the CTES v.3.0 uses personal pronouns (e.g., "I have been able to convey to my client(s) that the way they are feeling is understandable") and the CTSMS does not. Instead, the CTSMS describes a skill somewhat impersonally, such as "Collaboration. E.g., Encouraging patients to be active in sessions and participate actively in therapeutic teamwork". One possible explanation for the CTSMS's significantly lower baseline mean (when compared to the other measures) is that seemingly impersonal rating scales may reduce therapist overrating, and consequently elicit more objective and/or realistic responses when compared to scales that use personal pronouns.

Self-Practice/Self-Reflection and Stress

Scores for the PSS improved for four out of seven participants, with a mean decrease of 15% between the baseline and follow-up stages (n = 4). Improvements varied in significance, ranging from 7.5% - 30% during this timeframe. It is worth noting that the mean score at baseline was 42.85%, leaving reasonable room for improvement (42.85%). Although an increase in perceived stress was observed for Participant 1 (10%), Participant 3 (2.5%), and Participant 6 (7.5%) between the baseline and follow-up stages, a decrease was observed for Participant 3 (15%) and Participant 6 (25%) when the pre-intervention and follow-up scores

were compared. The increase in scores between the post-intervention and follow-up stages could possibly be due to drop-off effects: Participant 3 and Participant 6 both reported a reduction in perceived stress between the pre- and post-intervention stages, but these results did not appear to be sustained once the SP/SR program had concluded. Additionally, Participant 7's score improvement was not observed until the follow-up stage (once the SP/SR had ended). This suggests that the SP/SR program itself and/or postgraduate study in general may have been an important contributor to this participant's stress (possibly resulting from an increased workload and/or additional time pressures associated with study). To accommodate this, future research may benefit from using a tool designed specifically to measure stress management skills as opposed to perceived stress (as Participant 7 may have enhanced their stress management skills despite experiencing higher levels of stress over the course of the study). Furthermore, future SP/SR programs could be further developed to specifically address the issue of stress (e.g., by pre-empting the issue in the introductory chapters of the SP/SR workbook and/or by utilising CBT techniques to improve stress management). All in all, these findings tentatively suggest that SP/SR may enhance the stress management skills of CBT trainees, and provide quantitative evidence for the use of SP/SR in enhancing therapist self-care (as suggested by Haarhoff & Thwaites, 2016). However, these findings also indicate SP/SR may need to be ongoing in order to sustain the effects on therapists' perceived stress.

Individual Case Studies

In order to accommodate the necessarily small sample size, the data was treated both as a group and as seven individual case studies. This allowed for comparison between participants (using group data) in addition to comparison within each participant's individual data set. Consistent with current literature (e.g., Bennett-Levy et al., 2003), the individual case study findings indicate that SP/SR may impact different therapists in different ways (e.g., a mean increase in empathy scores overlooks the fact that one participant experienced a

substantial decrease of 19.5% for the CTES v.3.0 and the possible reasons for this). In particular, the individual case study data provided useful context in order to better understand the data as a whole. For example, although mean scores improved for all six of the quantitative measures used, one participant appeared to have been primarily negatively impacted by the SP/SR program: Participant 6's scores deteriorated for four out of six measures (the CTES v.3.0, CFI, PSS, and SRIS). Although on the surface this indicates a possible resistance to engagement in SP/SR (and highlights the potential negative effects of SP/SR for certain individuals), visual inspection of Participant 6's data set as a whole provided a number of alternative explanations for these findings. Firstly, Participant 6's score for the CTSMS improved by 28.1% between the baseline and follow-up stages, indicating enhanced self-monitoring skills. Thus, it is possible that the four score decreases observed are a result of enhanced self-awareness and, consequently, more realistic self-ratings (as opposed to the genuine deterioration of therapist skills). In addition, when the pre- and post-intervention scores were compared, Participant 6's scores actually improved for five out of six measures. This finding is supported by the qualitative thematic analysis results, as Participant 6 reported a positive impact of SP/SR on their personal and professional development.

Experience of Self-Practice/Self-Reflection

Thematic analysis of the qualitative data identified five themes regarding the participants' experience of SP/SR: (1) enhanced empathy, (2) the importance of collaboration, (3) the development of helpful tools to address problems, (4) time constraints as a potential barrier, and (5) an overall positive impact on personal and professional development. First and foremost, the qualitative data provides useful context in which to interpret the quantitative findings. For example, participants unanimously reported experiencing an overall positive impact of SP/SR on both personal and professional development, despite the fact that three out of seven participants' scores decreased for at least one of the quantitative measures. This

suggests that the perceived benefits of SP/SR were considered of greater value than any negative effects experienced by participants (e.g., increased stress). In addition, these findings provide support for both the current study (e.g., in terms of enhanced empathy) and for the wider SP/SR literature (e.g., Bennett-Levy et al., 2001; Bennett-Levy et al., 2003; Davis, 2008; Haarhoff et al., 2011; Gale & Shroder, 2014; Davis et al., 2014). Furthermore, the thematic analysis identified time constraints as a potential barrier to SP/SR, as well as two additional effects of SP/SR that extend beyond the scope of this study: enhanced collaboration, and the development of tools used to solve personal and professional problems.

Current Research Limitations

Despite the value of the current study, a number of limitations are notable. Firstly, the limited sample size makes the generalisability of results difficult. However, as most SP/SR studies are conducted with a specialised sample (e.g., trainee and/or experienced therapists engaging in CBT development), the current sample represents a significant proportion of this wider sample. This limitation may further be addressed by the reproduction of the study with additional samples (e.g., using the same workbook to facilitate SP/SR and the same quantitative measures to assess its impact). Secondly, the study utilises self-report measures and as such cannot be considered entirely objective: participants' self-ratings may be effected by personal biases (e.g., the social desirability bias). No methods were employed to confirm the accuracy of participants' self-ratings. This limitation may be addressed with the addition of external competence ratings alongside participant self-ratings (e.g., by observing the participants in a therapy session at each of the data-collection stages and externally rating the skills and competencies).

Finally, participant over-rating may have contributed to the high baseline scores for five of the six quantitative measures used, leaving limited room for participants to improve scores

for the associated skills and competencies. When Saxon and Barkham (2012) investigated the therapeutic effectiveness of 119 therapists treating 10,786 clients across a range of UK counselling and psychological therapy services, they found that 18% of therapists were excellent, 66% were good, and 16% were poor. However, when mental health professionals were asked to rate their overall clinical skills and performance compared to others in their profession, 25% assessed themselves to be in the top 10%, the remaining 75% assessed themselves as above average, and none rated themselves as below average (Walfish, McAlister, O'Donnell, & Lambert, 2012). This suggests that therapists tend to overestimate their abilities, further indicating that the participants in the current study may have engaged in over-rating. This limitation may be addressed by outlining these findings (regarding therapist over-rating) prior to the study to enhance awareness of the issue. Furthermore, the use of impersonal rating scales may reduce over-rating, as demonstrated by the CTSMS.

Implications of Findings and Suggestions for Future Research

Results from the current study indicate that SP/SR may enhance six important dimensions of CBT therapist competence: cognitive flexibility, empathy, insight, self-compassion, self-monitoring, and stress management, among CBT trainees. The findings provide valuable quantitative (and some qualitative) support for the use of SP/SR as a CBT training and development strategy, particularly when targeting these aspects of therapist competence. Of particular note are the quantitative findings regarding self-compassion and stress, as they provide preliminary support for the use (and further development) of SP/SR to improve therapist self-care and, consequently, reduce the physical and/or psychological problems commonly associated with therapist stress. In addition, results from the current study tentatively provide both quantitative and qualitative support for the use of SP/SR to enhance the collaboration skills of CBT trainees. However, additional research is needed to better understand the extent to which SP/SR impacts each of these dimensions, and to establish how

SP/SR may best be utilised as a CBT training and development strategy. In order to promote homogeneity (and thus increase research comparability and enhance the reliability of findings) it is suggested that future studies also employ a quantitative methodology and/or attempt to replicate the current study.

In an attempt to reduce the discrepancy between baseline and pre-intervention measure scores, it is recommended that future studies include a tutorial regarding how to use the measures prior to the commencement of the study. This may reduce any effects of participants' initial unfamiliarity with the measures and lead to the enhanced reliability of participant self-ratings. Furthermore, in light of the substantially lower baseline scores observed for the CTSMS (the only scale that did not use personal pronouns), it is suggested that future studies utilise impersonal rating scales to measure the various dimensions of CBT therapist competence. The measures used in the current study could be adapted to read more like the CTSMS by removing the personal pronouns: for example, "I have been able to convey to my client(s) that the way they are feeling is understandable" (an item from the CTES v.3.0) could become, "Empathy. E.g., Conveying to client(s) that the way they are feeling is understandable". However, additional research is required to determine the consistency of this finding.

Although thematic analysis of the qualitative data identified "the development of helpful tools to address problems" as a primary theme regarding the participants' experience of SP/SR, this finding is relatively unclear. Further research is needed to explore participants' definitions of the term "tools" in this context, in addition to which of the developed tools are perceived as most helpful in which areas of personal and professional life (e.g., the development of a time management "tool" may be perceived as having primarily personal benefits). Lastly, thematic analysis of the qualitative data identified time constraints as a potential barrier to SP/SR. This finding has important implications for the further development

of SP/SR, and has the potential to lead to improved SP/SR adherence and enhanced outcomes for CBT therapists. It is recommended that future SP/SR programs accommodate for this potential barrier by (a) pre-empting the issue (e.g., by adding a discussion regarding time constraints to the introductory chapters of the SP/SR workbook), and (b) incorporating exercises specifically designed to target the issue into the SP/SR program. Additional research is required in order to determine the reliability of this finding, as well as to assess the effectiveness of potential strategies used to accommodate this barrier.

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Appendix A: Adapted Cognitive Therapist Empathy Scale v3.0

Adapted Cognitive Therapist Empathy Scale (CTES) v3.

Please rate (0-100) how much you agree with the items below. The scale should be completed in relation to your practicum client. If work with your practicum client has not yet begun, please complete the scale in relation to another client you have worked with in the past seven days.

Completely disagree agree	Neither agree nor disagree	Completely
0	**50**	**100**

Cognitive Therapist Empathy Scale Items	Rating (0-100)
1. I have been able to 'tune in' to the verbal and non-verbal signs of my client(s)' emotional state.	
2. I have been able to have an experiential grasp of my client(s)' emotions beyond a purely intellectual understanding.	
3. I have been able to see things from my client(s)' perspective.	
4. I have been able to notice ways of behaving that my client(s) may not spontaneously tell me about.	
5. I have been able to convey to my client(s) that the way they are feeling is understandable.	
6. I have been able to use standard CBT techniques in ways that communicate empathy to my client(s).	
7. I have been able to show an acceptance of my client(s)' way of thinking without necessarily agreeing with it.	
8. I have been able to create a sense of effective collaboration and 'we-ness' between myself and my client(s).	

9. I often have problems staying emotionally present with my client(s) when they are experiencing difficult or painful emotions.	
10. I can always feel compassionate towards client(s) who struggle to change their behaviour.	
11. When I am with a client who is experiencing distress, it evokes in me the urge to help.	
12. I have felt irritated at my client(s).	
13. I have overlooked or dodged therapeutic opportunities e.g. due to fatigue, lack of emotional capacity, cognitive overload.	
14. I have been going into my sessions wanting to do the most I can to help my client(s).	
15. I have had enough knowledge about specific disorders to be able to formulate and understand how my client(s)' way of thinking affects the way they feel and behave.	
16. My knowledge of the CBT model has allowed me to help my client(s) make sense of the way that they are feeling.	
17. I have been able to understand how important it is to actively communicate empathy in addition to experiencing it.	
18. I have been able to understand how important the role of collaboration is in CBT in helping my client(s) engage in potentially difficult tasks.	

Appendix B: Adapted Cognitive Therapist Self-Monitoring Scale

Adapted Cognitive Therapist Self-Monitoring Scale

Please rate (0-100) how much you agree with the items below. The scale should be completed in relation to your practicum client. If work with your practicum client has not yet begun, please complete the scale in relation to another client you have worked with in the past seven days.

Completely disagree agree	Neither agree nor disagree	Completely
0	**50**	**100**

Cognitive Therapist Self-Monitoring Scale Items	Rating (0-100)
1. Agenda Setting and Adherence e.g. Setting discrete and realistic targets, appropriate adherence to the agenda.	
2. Feedback e.g. Using two-way feedback to increase both mine and patients' understanding of key issues, to keep focus and to synthesise material.	
3. Collaboration e.g. Encouraging patients to be active in sessions and participate actively in therapeutic teamwork.	
4. Pacing and Efficient Use of Time e.g. 'Time managing' sessions in relation to agenda, sessions flowing smoothly through discrete start, middle & concluding phases. Pacing material well in relation to patients' needs & learning speeds.	
5. Interpersonal Effectiveness e.g. Putting patients at ease by verbal & non-verbal behaviour, conveying empathy, genuineness and warmth.	

6. Eliciting Appropriate Emotional Expression e.g. Facilitating the maintenance of manageable levels of emotion in patients, dealing effectively with emotional issues that interfere with effective change	
7. Eliciting Key Cognitions e.g. Facilitating patients' access to thoughts, assumptions and beliefs; helping them to understand the relationship between these and their distressing emotions.	
8. Eliciting Behaviours e.g. Helping patients gain insight into the triggering and maintaining effect of their behaviours with respect to problems.	
9. Guided Discovery e.g. Using effective questioning to help patients develop new perspectives regarding their current situation which provides opportunities for re-evaluation and new learning to occur.	
10. Conceptual Integration e.g. Helping patients to gain an understanding of the history, triggers and maintaining features of their problems in order to bring about change in the present and future.	
11. Application of Change Methods e.g. Using, and helping patients to use, specific cognitive and behavioural techniques aimed at effecting change to emotional states and behaviours in line with the formulation. Helping patients to identify potential difficulties and think through the cognitive rationales for performing the tasks.	
12. Homework Setting e.g. Negotiating homework tasks with clear and precise goals that fit the stage of therapy and the formulation.	

Appendix C: Cognitive Flexibility Inventory

Cognitive Flexibility Inventory Client: _____ Date: _____

Please use the scale on the left to indicate the extent to which you agree or disagree with the following statements.

		Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
1.	I am good at ''sizing up'' situations.	1	2	3	4	5	6	7
2.	I have a hard time making decisions when faced with difficult situations.	1	2	3	4	5	6	7
3.	I consider multiple options before making a decision.	1	2	3	4	5	6	7
4.	When I encounter difficult situations, I feel like I am losing control.	1	2	3	4	5	6	7
5.	I like to look at difficult situations from many different angles.	1	2	3	4	5	6	7
6.	I seek additional information not immediately available before attributing causes to behavior.	1	2	3	4	5	6	7
7.	When encountering difficult situations, I become so stressed that I cannot think of a way to resolve the situation.	1	2	3	4	5	6	7
8.	I try to think about things from another person's point of view.	1	2	3	4	5	6	7
9.	I find it troublesome that there are so many different ways to deal with difficult situations.	1	2	3	4	5	6	7
10.	I am good at putting myself in others' shoes.	1	2	3	4	5	6	7
11.	When I encounter difficult situations, I just don't know what to do.	1	2	3	4	5	6	7
12.	It is important to look at difficult situations from many angles.	1	2	3	4	5	6	7
13.	When in difficult situations, I consider multiple options before deciding how to behave.	1	2	3	4	5	6	7
14.	I often look at a situation from different viewpoints.	1	2	3	4	5	6	7
15.	I am capable of overcoming the difficulties in life that I face.	1	2	3	4	5	6	7
16.	I consider all the available facts and information when attributing causes to behavior.	1	2	3	4	5	6	7
17.	I feel I have no power to change things in difficult situations.	1	2	3	4	5	6	7
18.	When I encounter difficult situations, I stop and try to think of several ways to resolve it.	1	2	3	4	5	6	7
19.	I can think of more than one way to resolve a difficult situation I'm confronted with.	1	2	3	4	5	6	7
20.	I consider multiple options before responding to difficult situations.	1	2	3	4	5	6	7

Appendix D: Perceived Stress Scale

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to indicate by circling *how often* you felt or thought a certain way.

Name _____ Date _____

Age _____ Gender (*Circle*): **M F** Other _____

	0 = Never	1 = Almost Never	2 = Sometimes	3 = Fairly Often	4 = Very Often
1. In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2. In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
3. In the last month, how often have you felt nervous and "stressed"?	0	1	2	3	4
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
5. In the last month, how often have you felt that things were going your way?	0	1	2	3	4
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
7. In the last month, how often have you been able to control irritations in your life?	0	1	2	3	4
8. In the last month, how often have you felt that you were on top of things?	0	1	2	3	4
9. In the last month, how often have you been angered because of things that were outside of your control?	0	1	2	3	4
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

Please feel free to use the *Perceived Stress Scale* for your research.

Mind Garden, Inc.
info@mindgarden.com
www.mindgarden.com

References

The PSS Scale is reprinted with permission of the American Sociological Association, from Cohen, S., Kamarck, T., and Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24,* 386-396.

Cohen, S. and Williamson, G. Perceived Stress in a Probability Sample of the United States. Spacapan, S. and Oskamp, S. (Eds.) *The Social Psychology of Health.* Newbury Park, CA: Sage, 1988.

Appendix E: Self-Compassion Scale – Short Form

Running head: SELF-COMPASSION SCALE–Short Form (SCS–SF) 2

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	2	3	4	5

_____1. When I fail at something important to me I become consumed by feelings of inadequacy.

_____2. I try to be understanding and patient towards those aspects of my personality I don't like.

_____3. When something painful happens I try to take a balanced view of the situation.

_____4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____5. I try to see my failings as part of the human condition.

_____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____7. When something upsets me I try to keep my emotions in balance.

_____8. When I fail at something that's important to me, I tend to feel alone in my failure

_____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____11. I'm disapproving and judgmental about my own flaws and inadequacies.

_____12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Reference:
Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the Self-Compassion Scale. *Clinical Psychology & Psychotherapy. 18*, 250-255. Used by Permission.

Appendix F: Self-Reflection and Insight Scale

SRIS

Please read the following questions and circle the response that indicates the degree to which you agree or disagree with each of the statements. Try to be accurate, but work quite quickly. Do not spend too much time on any question

THERE ARE NO "WRONG" OR "RIGHT" ANSWERS – ONLY YOUR OWN PERSONAL PERSPECTIVE

BE SURE TO ANSWER EVERY QUESTION ONLY CIRCLE ONE ANSWER FOR EACH QUESTION

	Disagree Strongly	Disagree	Disagree Slightly	Agree Slightly	Agree	Agree Strongly
	1	2	3	4	5	6
1. I don't often think about my thoughts						
2. I am not really interested in analyzing my behaviour						
3. I am usually aware of my thoughts						
4. I'm often confused about the way that I really feel about things						
5. It is important for me to evaluate the things that I do						
6. I usually have a very clear idea about why I've behaved in a certain way						
7. I am very interested in examining what I think about						
8. I rarely spend time in self-reflection						
9. I'm often aware that I'm having a feeling, but I often don't quite know what it is						
10. I frequently examine my feelings						
11. My behaviour often puzzles me						
12. It is important to me to try to understand what my feelings mean						
13. I don't really think about why I behave in the way that I do						
14. Thinking about my thoughts makes me more confused						
15. I have a definite need to understand the way that my mind works						
16. I frequently take time to reflect on my thoughts						
17. Often I find it difficult to make sense of the way I feel about things						
18. It is important to me to be able to understand how my thoughts arise						
19. I often think about the way I feel about things						
20. I usually know why I feel the way I do						

Grant, A. M., Franklin, J., & Langford, P. (2002). The Self-reflection and Insight Scale: A new measure of private self-consciousness. Social Behavior and Personality, 30, 821-836. – *Permission is freely granted to use this scale for research and therapeutic/coaching purpose. Commercial use of this scale requires written permission from A. M .Grant. Email:* anthonyg@psych.usyd.edu.au

Appendix G: Participant Information Sheet

Evaluating Self-Reflection and Cognitive Flexibility in Postgraduate Cognitive Behaviour Therapy Trainees

Research Study Information Sheet

You are invited to take part in research evaluating the impact of a self-practice/self-reflection intervention on self-reflection, cognitive flexibility, self-compassion, and self-care in postgraduate cognitive behaviour therapy trainees. Before deciding whether you wish to be involved in the research, please read the following information carefully to ensure you fully understand the nature of the research project and your rights as a participant.

What is the study about?
As you already know, self-practice/self-reflection (SP/SR) is an experiential training strategy that provides therapists with a structured experience of using cognitive-behavioural therapy (CBT) on themselves (self-practice) and reflecting on that experience (self-reflection). Research findings across several countries suggest that SP/SR enhances understanding of CBT, CBT skills, confidence as a therapist, and belief in the value of CBT as an effective therapy. Research also suggests that the impact of SP/SR appears to be as valuable for experienced therapists as it is for novice therapists.

What is lacking in the current body of research, however, is the use of objective measures. This study will use six objective measures (the Cognitive Flexibility Inventory, Cognitive Therapist Empathy Scale, the Cognitive Therapist Self-Monitoring Scale, the Self-Reflection and Insight Scale, the Christen Neff Self Compassion Scale, and the Perceived Stress Scale) to better understand the impact of SP/SR on clinical practice in regards to five components (reflective ability, cognitive flexibility, empathy, competence, and self-care).

Who is able to take part?
To participate in this research, you need to be enrolled in a postgraduate programme of cognitive behaviour therapy (e.g., the Postgraduate Diploma in Cognitive Behaviour Therapy at Massey University) and completing the SP/SR practicum course component.

What would I have to do?
If you agree to participate, you will be asked to complete a set of 6 measures pertaining to the SP/SR component of your Postgraduate Diploma at 5 stages throughout the year. The dates are as follows;

- Monday 18 April 2016
- Monday 9 May 2016
- Monday 13 June 2016
- Monday 5 September 2016
- Monday 21 November 2016

The measures will be posted to you a week prior to each of the above dates to ensure you have adequate time for completion. It is estimated that each measure will take 2-3 minutes to complete, thus each set of 6 measures will require approximately 15 minutes of your time. A prepaid and

addressed envelope will be included with each set of measures, and you will be asked to return the filled-out measures by the above dates.

How will the study benefit me?
Participation in this study is expected to enhance what you take away from the SP/SR practicum component of your course by identifying the skills and understanding developed (as a result of the SP/SR component) in an objective manner. We hope this knowledge will encourage you to continue with SP/SR in the future, and thus enhance your practice as a cognitive behaviour therapist.

In addition, every participant will receive a $50 gift voucher at the conclusion of the study.

Will my information remain confidential?
Yes. All your information will remain confidential at all times as part of standard procedures within the Massey University School of Psychology.

- Research data will only be accessed by the researchers and clinical supervisors directly related to this study.
- Research data will be anonymised from Dr. Beverley Haarhoff, as she is your course co-ordinator.
- No material which could personally identify you will be used in any reports of this study.
- All data will be kept in a locked cabinet and information entered for analysis in a password protected file.
- Files will be stored in a separate location from identifying information.
- You will not be personally identifiable in any research publications (e.g., in scientific journals) that result from this research.

Your rights as a participant:
If you choose to take part in the research, you have the right to:

- Withdraw from the study at any time;
- Decline to take part in this study, knowing this will not have any impact on your course results;
- Decline to answer any particular question;
- Ask any question about the study at any time during participation;
- Be given a summary of the findings of the study once it has been completed if you request it.

Questions or concerns:
If at any time you have questions or concerns about this study, you are welcome to contact Dr Beverly Haarhoff, phone (09) 414 0800 ext. 43105.

What happens from here:
Please read over the enclosed consent form and fill it out at your earliest convenience. Also enclosed is the first set of measures, to be completed in the forthcoming week. We ask that you return the consent form and the completed measures using the envelope provided by Monday 18 April.

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named in this document are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researchers, please contact Dr Brian Finch, Director – Ethics, phone (06) 356 9099 ext. 86015, email humanethics@massey.ac.nz.

Thank you for reading this information sheet.

Appendix H: Participant Consent Form

Evaluating Self-Reflection and Cognitive Flexibility in Postgraduate Cognitive Behaviour Therapy Trainees

Participant Consent Form

This consent form will be held for a period of ten (10) years.

I have read the information sheet for this study. My questions about the research have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given contact details to use in case I have future questions about the study. I have also had the opportunity to use whanau / family support or a friend to help me ask questions and understand the study.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time.

I agree to provide information to the researchers. The information I supply will only be used for the purpose of this study. All information will be treated confidentially within the School of Psychology, subject to the ethical guidelines on the limits of confidentiality provided by the Psychological Society of New Zealand's Code of Ethics, as per the Privacy Act (1993).

I have had adequate time to consider whether or not to take part in this study. I agree to participate in this study under the conditions set out in the information sheet.

Signature…… Date……

Full Name (printed)

……

Appendix I: Participant Instructions

Evaluating Self-Reflection and Cognitive Flexibility in Postgraduate Cognitive Behaviour Therapy Trainees

Dear Participant,

Thank you for your ongoing participation in our study, it is much appreciated.

You will find the fifth and final set of measures enclosed here, in addition to a prepaid envelope. Once completed, please return the measures via post (preferably by Monday 21 November).

As a token of our gratitude for your valuable participation, you will receive a $50 gift voucher following the conclusion of the study.

Thank you again for your time.

Kind regards,

Fleur Hume.
p.p. Dr. Beverly Haarhoff

Appendix J: Demographic Information Sheet

Evaluating Self-Reflection and Cognitive Flexibility in Postgraduate Cognitive Behaviour Therapy Trainees

Participant Demographic Information

Date of birth: _____

Ethnicity: _____

Current occupation/place of work: _____

_____

Is your current place of work publicly or privately funded? _____

Professional background: _____

_____

_____

_____

_____

Years of experience in mental health: _____

Appendix K: Participant Reflections

Participant 1: Module 6, 12/06/16

I have enjoyed some aspects of the SP/SR more than others. I really enjoyed doing the thought records/evidence for & against/coming up with a balanced thought. I found using the balanced thought helpful to look at what and how I can break out of my maintaining cycles.

What I know is when I feel overwhelmed as I have been over the past few weeks I need to take a break, reflect and re-organise myself. I felt having a weeks break away from work, study and home helpful to put things back in to perspective. Interesting the SP/SR have been a really excellent tool to help me reflect on what impacts on me and how this plays out in therapy i.e.: I feel overwhelmed and rushed therefore go into sessions where I overwhelm and rush with clients. My learning has been to slow down - what's that saying 'slow and steady wins the race'.

I feel at times I do not give enough time to SP/SR and find rushing makes me feel frustrated and annoyed with the process whereas the times I have allowed a little more time I have enjoyed the modules more and been able to reflect more effectively.

From this module I have decided to get more balance in my life. I need to look at implementing an acitivity schedule to include work related issues, study and pleasure so that I am able to find balance and elevate my stress/feelings of being overwhelmed. I know that scheduling is a helpful tool for me and acknowledge at times I will need to be flexible to include unforeseen matters that arise. All I know is lately things have been out of balance and this has taken it's total as getting sick especially seeing I don't get sick very often is a key sign for me.

Participant 1: Module 12, 08/09/16

I found the use of metaphors and imagery really useful in bulding my new way of being. I liked the movement exercise as well as I used exercise such as yoga and pilates which helped my feel more balanced especially with my work life pressures. I am very aware that I need to look after my physical and emotional wellbeing to keep my new way's of being active.

I found the use of experiential strategies really reinforced my cognitive process. I can't see how you can do one with out the other as this helps effect the change process and challenges negative thinking styles. This provided me with more evidence for my new ways of being resulting in me feeling more positive and happy to engage in the process.

By creating a maintenance plan was helpful as this is a bit like the relapse planning exercise I a;ready do with my clients.

I have enjoyed the SP/SR process although at times I would have liked to have more time to reflect on the process. I feel by engaging in this process it has enhanced my practice as I have a better understanding of what I am asking clients to do that I am also prepared to do the task with them if required or to problem solve difficulties in engaging in the task. Personally I have also gained a lot.

I definitely will continue SP/SR as this will enhance my practice further. I think using this within my professional supervision is a good place for this to continue. One thing that might get in the way is to find a supervisor who can provide good CBT supervision and is willing to encourage me to engage in CBT tools i.e.: doing BE's etc.

Participant 2: Module 6, 12/06/16

The exercises have been helpful in focusing my mind on the possibility of alternative ways of looking at my issue and developing a more balanced perspective. I have enjoyed doing the worksheets and particularly enjoy doing thought records and I have been doing these in my own

time, I find them helpful in stopping myself from thinking to much about issues when I recognise my thinking as being unhelpful.

What has really stood out for me is how helpful I find doing thought diaries and how helpful the process of looking at my problem has been reassuring and it has stopped me from worrying and being more productive in addressing my issue. It has made me realise that I need to be more active in problem solving and follow plans that I put together. It made me realise that I'm not always good at doing what will be better for me. This realisation I am hoping will make me more productive. Already I have put together a better plan for me actively addressing my issue.

I am a reflector and have been engaged in reflective practice since doing my nurse training. I have really enjoyed doing the exercises as it have given my current reflective practice an even broader range of tools that I can use.

I have found that the SP/SR was initially suppose to be addressing an issue in my therapist self. However it has become much broader and does cross into my personal self. The way I have seen this is that the issue I am identifying in my therapist self has much deeper roots than being an issue that has just come up through doing the course. This issue is a big part of my personal self and I see it cross sectionally. It uncovered a core belief that I have.

Currently I can see a number of clients I am involved in who would benefit from this experience and making sense of the difficulty they are experiencing. But unfortunately I am unable to put this into practice as these clients are engaged in a different form of therapy and I am unable to engage them in CBT. As I can't put this into practice with these clients I do still think about their issues using a CBT approach and weighing up the benefits in comparison to a psycho-dynamic model.

Sometimes I think I would have benefited from starting the exercises at the beginning of the week rather than mid week as this will give me more time to work on the issue and more opportunity to do the exercises. This will improve my overall reflections having had more time to think about and consider what I am doing.

I have really enjoyed the problem solving aspect of it and some of the work sheets I have used I could see being valuable in how I approach problem solving with my clients.

Participant 2: Module 12, 04/09/16

For me a combination of Behavioural Experiments and imagery have been most effective in building my belief in my new way of being as well as doing thought diaries to generate new ways of thinking when my old ways of being pop into my head.

As I have worked through the book Experiencing CBT from the Inside out I have been able to see how experiencing and observing situations and using cognitive strategies are effective when used together. It has been good learning cognitive strategies for changing the way I think and doing behavioural experiments has given me the opportunity to test out my thoughts. I found having a plan to keep me on track helpful which trouble shooted some of the potential problems that could come up and get in the way. I see experiential and cognitive strategies as being most effective when used together.

When I did My New Ways of Being Maintenance Plan I was surprised by how easy the process of filling out the boxes was and how positive I was feeling about maintaining the changes I have made. Through doing this it has given me an experience of how doing CBT can be for our clients and some of the problems that can come up and how to ensure the goals we are setting our clients are achievable. I felt happy and excited by what I had achieved as I hadn't thought the amount of time I had been able to give a week to doing this would bring about so much change.

I envisage continuing with SP/SR in the future. Through my nursing practice I have developed a reflective way of working and I envisage that I will continue working in this way with my CBT practice.

Participant 3: Module 6, 09/06/16

Completing the workbook has been a good experience so far.

With the self-practice, I particularly liked doing the activity schedule. I learned so much more about it. I am presently benefiting from doing an activity schedule. Initially, I could not imagine how I would be able to add more activities to my already packed schedule. Similar to rating the activities according to the degree of difficulty (as in the workbook), I rated my activities according to their importance, managed to reduce some repetitive tasks that have been occupying my time. I was able to factor in pleasurable activities which I had been putting off. I liked the idea of reviewing the schedule after 4 days, something I trialed with my client with a good outcome. I also liked doing the thought record. It was good to experience the challenge in coming up with evidence which did not support the NAT and be able to synthesise evidence to come up with a more balanced view. I needed more practice in that aspect.

I was quite hard on myself when I was late in posting a comment in one of the modules. Time management is one of the main roadblocks. A lot of learning was gained from that. Doing SP/SR will have positive impact in my practice as well as my personal life.

I had no difficulties with the self-reflective questions. it was like a 'check' that clarified my learning and also allowed me to "dig deep" as to what I was taking from the modules. It enable me to synthesise my learning and identify beneficial key points.

Participant 3: Module 12, 02/09/16

The behavioral experiments had the biggest impact in building my belief in my new ways of thinking. I also found it quite enjoyable as I was able to experience a new way of doing things/a new way of being. Several times, I heard the comment: ”It’s not like you not to……”. I was a bit uncomfortable at the start, but as I carried on with the planned BEs and my new way of being, I no longer felt like I had to explain anything or justify myself. I often joke back now for everyone to “embrace the new me”. I also found the thought record very useful. It’s nice to be able to check myself, to practice being open-minded each time I feel emotional about anything. It’s like a little open debate in my head, which allowed me to consider far more options/possibilities than I did before. I am also continuing with the activity schedule. In the past, this would mostly be about work schedules. Nowadays, I try as much as possible to work out a good work-life balance in my activities. It’s been a lot better looking forward to enjoyable activities even on workdays. I used to relegate pleasurable activities only on my 2 days off but that is no longer the case.

To me, cognitive and experiential strategies work best together, hand in hand. They complement each other. Use of both strategies is effective in initiating and maintaining change. As in the workbook, behavioural activation was a good initial approach to set the wheel in motion, effect improvements in mood and reinforce ‘small victories’. It was a good preparation to tackle the more emotionally laden situations when using the cognitive strategies. Continued use of both strategies helps maintain new ways of learning/being.

Having a written Maintenance Plan increases commitment and accountability on my part to adhere to my new way of being. Seeing the plan on paper gives me a clear goal-direction, structure and organisation. There were no surprises for me but I was amazed at what I have achieved, like I said before, it was like reinventing myself.

Realising the value and importance of my own Maintenance Plan underlined the importance of ensuring that a Relapse Plan is completed collaboratively with my therapy clients in the future. The plan is also a tool by which the client’s progress and strengths can be acknowledged.

'Experiencing CBT from the Inside Out' has been very informative and challenging. It has helped me a lot in developing my reflective skills and gave me the invaluable knowledge of being 'on the other side' with self-practice. Best of all, I am really amazed with the changes I have made and very happy with my new way of being.

From a professional perspective, the important "take-home" messages from this workbook would be the main focus on the client's unique individual experiences and idiosyncrasies, the importance of collaboration when working with clients and focus on ongoing learning to be a competent therapist. From a personal perspective, the "take-home" messages would be the great value of ongoing self-reflection and the added optimism that 'yes, I could make changes'.

It would be of great value to continue with SP/SR in the future. I plan to have a regular, ongoing review of my Maintenance Plan on a 3-monthly basis. I am optimistic regarding this ongoing plan and unable to identify any barriers at this point.

Participant 4: Module 6, 14/12/16

I have found SP/SR to be such a rewarding opportunity and the first half of the programme has indeed been very confronting. I have had moments where I became really self-critical and even times where I was like "so that's why I am the way I am" upon reflection. Being able to try out strategies before trying them with my client has also been an invaluable experience, and has only strengthened my understanding of the process.

The main difficulty I have had was being able to fully commit myself to the programme. I initially started off really well but then I faded off. Upon reflection I think time became my enemy and also wanting to make a thorough attempt at completing each module, which ended up taking hours. In the process I decided that if I wasn't able to do it properly, then there wasn't any point doing it. I was absolutely wrong about that…there is always time for self-reflection. I have always thought of myself as a reflective person but in terms of completing the SP/SR programme I needed to develop a way of doing it in a way that worked for me. Discussing this in supervision helped me to complete my own experiment on how to do this. So far…it is going ok.

Noticeably I have seen a change in myself personally and also professionally, in terms of my reflective capacity. Being able to take a moment to sit back, think about what is happening and to listen to my clients without necessarily having all the answers has become such a powerful tool for me to use in my practice. It also conveys empathy and understanding which people in difficult situations need, so I am proud that I can do that for them. I have also found ways of adapting my thinking and applying what has been learnt in these modules. This is something I will definitely continue to do both personally and clinically.

Participant 4: Module 12, 05/01/17

To be fair I found the first 6 modules of the SP/SR process the most rewarding because of my initial commitment to begin with. Due to a number of reasons I found it difficult to sustain the momentum I was initially making, which for me was a real let down. However, with lots of encouragement I knew that getting through the workbook and even being able to reflect on the experience of what I would have done was important. I have wholeheartedly made a promise to myself that when time allows and even when I am moving into working more with CBT clients, that I return to the SP/SR programme and complete it properly. One of the major benefits is having the self-reflection book to guide me in my practice, to help remind me of the skills that I can use to address my own therapy difficulties, and to be able to reflect and make changes where necessary.

I really do believe that the SP/SR process has helped to enhance my clinical practice and has given me the opportunity to be more aware of my own processes. It has given me more confidence in being able to see change as something that I have control over and provides me with insight to the difficulties my clients might also experience. I also like the fact that I am able to share these experiences first hand because I have completed the exercises/interventions myself, and can directly speak to them. This has the added benefit of helping to reassure my clients that I do understand how difficult it can be which should only enhance and strengthen the therapeutic relationship in my opinion.

As previously mentioned finding time to complete the modules has been the most difficult part of completing the SP/SR workbook. In the future I will need to ensure that this becomes a priority for me, and managing my time more effectively needs to occur so as to not fall behind. I am confident that I will be able to do this as I can see now how beneficial the process is both personally and clinically.

A highlight for me has been using cognitive strategies that I feel comfortable with, and have almost always used in my personal life. The power of imagery and how it has been better explained throughout the modules resonates well with who I am as a person and also as a clinician. I can see myself using it more with my clients alongside more experiential interventions, which are practical and can be tailored to suit them.

Finally, I am so BIG on self-reflection in my practice and in my personal life as well. For me I have always been one to think and feel but never one to act. I have never felt that I had the skills or experience to process these reflections and would normally just park my thoughts/feelings without any further thoughts or solutions. The SP/SR modules have provided me with ways of being able to now move forward and given me the skills/interventions I can use. I am looking forward to what lies ahead in the New Year and am thankful for being given this opportunity to explore my own cognitive processes more deeply.

Participant 5: Module 6, 17/08/16

Knowing that I am ½ way through the workbook a sense of relief because I have had so much else on my plate and so this milestone tells me I'm on the homeward stretch. **On an intellectual level the SR/SP exercises have made complete sense in the rationale of necessity and** importance in this qualification, but on a gut level they have been often met with an "Ugh, do I **have to?!** It's more stuff that I can't fit in my life right now". **Having said this, every one of the modules has been beneficial and added to my personal and professional insight. This will be important to keep in mind when working with busy/overwhelmed/resistant clients.**

I have been using the SR/SP to work on a professional issue. What I have experienced is that although the "therapist self" was what I was initially focused on, the "personal self" couldn't help **but be involved in this process, as certain behaviours and beliefs were cross-situational.**

From reviewing my progress I have gained a great deal from taking time out to investigate patterns at see what really goes on. In working with a particular client who is slow in progressing I have personally learnt the importance of unpacking the roadblocks and keeping ever mindful of the goals and strengths.

The SP has been extremely useful in learning more about various tools and their nuances, but the work holds a great deal more benefit when followed by SR. This SR elicits further insight and consolidates learning and change, and is in a nutshell the "what do you make of this then?" **question that is so important in answering.**

Participant 6: Module 6, 13/06/16

Overall an okay experience. What stood out for me is that I have been developing self-reflective practice for just under a decade, over time this has progressed into a self practice of compassion

and kindness. Having this established practice meant I experienced criticisms about the practices in the workbook (and at times CBT itself).

The reflective practices have not made me want to change or adapt what I consider to be well established practices but has developed a sense of gratitude for me. Gratitude for the fact that I have found a self practice that benefits. This is because there are a lot of confusing messages 'out there' about what happiness is and how to achieve it. This last point would be something I would be aware of if there was a client struggling with progress, by exploring with them the pros and cons of what they have already being doing to try and achieve happiness and supporting them to work out what has been working and why and what hasn't been working and why-written materials are good for this.

On reviewing progress I have enjoyed testing out interventions on myself before suggesting them to others, as well as making sure I have a sound rationale for the intervention-and being able to explain this in plain terms to the individual.

Participant 6: Module 12, 09/09/16

The reflective practice has been a learning curve, I have learnt more about the things that enhance wellbeing, communication and generally make life a little easier as well as learning about the things which I thought worked but in reality didn't do much for me. This at times was challenging and something that I would much rather not go through, but knew that the end result would be worth it.

Experiential interventions were the ones that I gained most learning from, and created the most learning and lead to making changes, cognitive interventions were ones that I could do more easily on the spot. Whereas I found that setting up experiments took more time, tweaking here and there, but found that it was much easier when I had a clear rationale about what I was testing out, it was then easier to set the experiment, easier to carry out and it wasn't so much about the outcome but the experience. With practice less time was needed to set up the experiments' so who knows with more practice perhaps I could do them on the spot as well (so to speak).

Creating a maintenance plan helped me observe the things that otherwise may have passed me by. I liked going from the problem to new ways of being, it helped me to develop new ways of being.

Will I continue?

It's good to have a variety of tools in the box because sometimes you need a hammer, other times you need a pen. So in this respect I can't say no, because that would be foolish.

Participant 7: Module 6, 12/06/16

So far SP/SR has been a really useful exercise - getting the first-hand experience of trying out the strategies on oneself is invaluable and a great learning tool. The parts I have found most interesting have been the TR, and also planning how to solve the obstacles to the achievement of my goals. I know that I have a tendency to set goals (bit like those New Year's resolutions) - **start off with great intentions and then fade. So thinking hard about how to get around the roadblocks has been interesting and I hope will help me to carry through on what I want to achieve (ie stick to it for the long-**haul, not just for a few days….)

I think SP/SR has been useful for both my personal self (as above) but also for my professional self as it has given me greater insight and has helped to stop being as self-critical as I had been.

With regard to client work, I do have a few clients who have some of the same tendencies that I do and it has helped me to see that with more empathy and to realise how important it is to collaboratively look at the obstacles to progress and problem-solving around those.

The self reflection that is part of the SP/SR process is probably the hardest part as it requires a good clear 'head space' and time - **and that can be hard to find. But without doing the reflection the learning would be quite superficial.**

Participant 7: Module 12, 05/09/16

I found reflecting on the New Ways of Being really useful. The process of articulating New ways of thinking and New Ways assumptions to test made me really focus my attention on the positive and to notice examples where I was having some success, rather than my old way of noticing the times I hadn't 'achieved' and in so doing ignoring what I had (filtering!).

Cognitive strategies (such as TR) are really useful for developing new ways of thinking, however these on their own may only produce head levels of belief. It is in testing out these new ways of thinking using experiential strategies such as BEs that gut levels of belief can be most powerfully impacted. The model provided in the SP/SR program of developing a 'cognitive' **conceptualisation of a New Way of Being and then backing this up with BEs to consolidate belief in the new assumptions shows how to interweave the cognitive and experiential strategies.**

Personally I found the development of a maintenance plan somewhat of a chore, possibly as I was trying to do it when tired. It seemed like a lot of effort and I didn't feel that motivated to think **about the issues anymore as I felt that I had made some positive changes. It did make me wonder if clients will sometimes have a similar reaction and that they may need encouragement to make the effort to think through a maintenance plan, especially if their symptoms have** reduced so they don't see the need to think about relapse. However, having now made the effort **to produce a maintenance plan I intend to review it in a few months time.**

Professionally, I think that the reflective skills practiced through the SP/SR program have been very beneficial. It has helped me to move from being highly self-critical to more compassionate towards myself. I have also come to value self-reflection more and to prioritise it. Working through many of the strategies we use with clients for myself helps with anticipating how client's **might react.**