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REVIEW PAPER

The importance of self-experience and self-reflection in training of cognitive behavioral therapy.

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Abstract

Self-awareness can be characterised as impartial, non-judgmental thoughtful attention towards the self. Self-reflection in therapy is when a therapist reviews their experiences, thoughts, and behaviours concerning therapy and changes them as needed to enhance the therapeutic process. Therapists with good quality self-reflection can make more effective and ethical decisions, differentiate their own needs from clients', understand transference and countertransference, and consider the optimal response during a session. Practising the CBT approach and reflecting on one's own experiences can be essential for successful therapeutic development. Furthermore, self-reflection forms the basis of a fruitful therapeutic relationship and the therapist's self-confidence and sense of competence.

INTRODUCTION

Conscious recognition of one's own emotions, feelings, thoughts, or attitudes at the time of their origin and the ability to monitor them and frequently realise them are examples of essential therapeutic skills. Boud *et al.* (1985) describe self-reflection as an intellectual and affective activity that individuals use to explore their experiences to understand better and evaluate them. The therapist's self-experience and self-reflection present relatively new areas of interest in CBT (Bennett-Levy *et al.* 2003, Laireiter & Willutzki 2003, Hoffart *et al.* 2006, Praško *et al.* 2012a; Bennett-Levy & Lee 2014). In the past, gaining self-experience was not a part of training in cognitive behavioural therapy. Cognitive behavioural therapists require their clients to self-monitor and capture their thoughts and attitudes or triggers of experience and behaviour (Praško

et al. 2007), but they usually do not have such experience themselves. CBT training contrasts with other psychotherapeutic approaches in which self-experience creates the base of the psychotherapist's development (Rogers 1967, Serok & Urda 1987; Skofholt & Ronnestad 1992; Yalom & Leszcz 2003, Rodolfa *et al.* 2005). CBT training focuses primarily on case conceptualisation, behavioural and functional analysis of patient problems, and the selection and practice of optimal strategies based on the conceptualisation (Wells 1997, Kuyken *et al.* 2009). This training provides students with the competence to treat patients who are not challenging. However when working with more complicated patients, especially patients with chronic problems, resistant to treatment or personality disorders, the therapeutic relationship and the therapist's self-reflection become more critical (Prasko *et al.* 2010, Prasko *et al.* 2012a).

METHOD

This article is a narrative review supplemented by the experience of CBT trainers whose training programs include self-reflection development. The text deals with the place of self-reflection in the training, its advantages, methods of its development, and potential issues in the training of cognitive behavioural therapists.

SENSE OF SELF-REFLECTION IN CBT

Bennett-Levy *et al.* (2001) conducted a qualitative study of trainees who underwent cognitive therapy (CT) training, including self-experience and self-reflection. Critical parts of the learning process were: (i) experiencing cognitive techniques from the client's perspective and (ii) reflecting on these experiences, which led to (iii) a "deeper understanding" of the practice of CT. The result of this training was an increased therapist's understanding. The trainees reported a deeper understanding of their role, the theory, and the change process. They also perceived that self-experience led to a greater understanding of oneself and CT as useful for personal development. They also observed improvements in their therapeutic skills and self-concept. The authors concluded that self-experience and self-reflection could be valuable in CT training. The work of Thwaits & Bennett-Levy (2007) subsequently conceptualised the nature and function of therapeutic empathy within CBT. They proposed a model with four key elements: (a) empathic attunement, (b) empathic attitude/stance, (c) empathic communication, and (d) empathy knowledge. The authors point out the importance of the concept of "therapist as a person" and self-reflection in therapeutic empathy development. They emphasise the value of personal experiential work and self-reflection to understand the patient's inner world and behaviour.

Understanding others through self-experience is emphasised by many papers (Bennett-Levy *et al.* 2001; Bennett-Levy *et al.* 2003; Prasko *et al.* 2012a). In evaluating three of our training courses in 2012-2013, the participants stated that the most helpful training and supervision components were self-experience and the therapy structure, which they rated as significantly more important than skills training and therapeutic process (Vyskocilova & Prasko 2014).

SELF-AWARENESS AND SELF-REFLECTION

Self-awareness can be characterised as impartial, non-judgmental attention focused on the inner self (Goldmann 1995). It is the ability of conscious self-knowledge, self-definition and self-evaluation, based on which it is possible to formulate a relationship with oneself (Vyrost & Slamenik 1997). The content of conscious self-reflection consists of three main aspects: self-awareness, self-evaluation as a process, and the result of this process, observable behaviour, or external manifestation of the self (Hupkova 2010). As a vigilant observer, self-reflection impartially accepts everything that passes through consciousness. The term meta-cognition is used to denote awareness of one's thought and attitude processes, and the term meta-mood is used to denote awareness of one's emotional processes (Wells 1997). We will use the term self-reflection or self-awareness for both aspects because cognitive and emotional reactions usually co-occur.

Self-reflection in therapy has been described as a process in which a therapist assesses their emotional and cognitive experiences and realises their behavioural responses, gains insight through internal dialogue and generalisation, and changes their original attitudes and beliefs about the therapeutic situation (Kolp 1984, Schon 1987, Kimmerling *et al.* 2000, Beck *et al.* 2004, Thwaites & Bennett-Levy 2007). Self-reflection is not a finite process; individuals and their experiences continually change and evolve, similarly to never-ending external information and relationship changes.

There are many methodologies of self-reflection; for example, Trapnell & Campbell (1999) define self-reflection as a motivationally driven curiosity about oneself (e.g., "I love exploring my 'inner' self"), whereas Grant *et al.* (2002) define self-reflection as a combination of motivation and engagement (e.g., "I need to evaluate the things that I do"; "I frequently examine my feelings"). According to the SSR model (Crane *et al.* 2019), self-reflection assessment should focus on the coping process to produce insights that aid in refining and developing resilience capacities(Bucknell, Kangas & Crane, 2022).

As mentioned above, reflection has been considered one of the core competencies in various disciplines, and it is exceptionally well-documented in the healthcare industry (Cathro *et al.* 2017). Without reflection, there would not be a learning process (Hans-Ueli Schlumpf 2020).

NEED FOR SELF-REFLECTION

In their experience, evaluation and actions, the individual is carried away by motives, needs, impulses, ideas and wishes, which they may be aware of only partially, or sometimes not at all (Prasko *et al.* 2012a) even though these motives influence the individual (Prasko *et al.* 2010). For example, the need to help can present an unconscious defence, compensating for the inability to experience and express own emotions and needs (Schmidbauer 2008). Similar attitudes function in therapy in various ways. They can manifest by a withdrawal, feigned excessive effort, or criticism that the therapist rationalises as necessary. The therapist may then refuse to treat the client anymore or force them to be hospitalised. Here are some examples of unreflected therapeutic help for others:

- There are, for example, therapists who help clients mainly out of *duty*. They may have deeply instilled feelings of duty and rules of what they should and should not do. These feelings and attitudes can arise from a strict or a bigoted upbringing or an attempt to behave differently from the "irresponsible" parents. Such an obligation can be excessive, sometimes burdensome. The therapist does not want to/feel up to the task, but they know that the given client urgently needs their help to provide it to them at the moment. Simultaneously, they are disgusted or tired and often behave formally, not concentrating on the client or understanding them.
- Another hidden unreflected motive for helping others may be the *need to feel important*. Individuals who have often suffered from a lack of this need might seek it in therapeutic work. As children, they did not feel important to their parents, paid little attention to them or humiliated them, did not feel important to their peers, felt inferior, etc. Even when others refuse, that can develop into a "saviour complex," a strong urge to help. There is an impression that the therapist must not reject anyone. Even if they have lasting emotional relationships, they are strongly influenced by a professional role. In return, the helper gains professional success, but it usually does not satisfy them forever (Schmidbauer 2008).
- The *need for power and control* can also motivate helping people (Adler 1993). The therapist might feel good about having power over their clients, but it devalues their therapeutic work and usually worsens the therapeutic effectiveness and ethical environment. The therapeutic situation can repeatedly stimulate feelings of omnipotence, and the therapist experiences how dependent the client is on them in many ways. The therapist can become the most critical person in the client's life, the only person who feels understood and supported. The urge for power is usually not manifested fully but appears under the guise of the therapist's objectively and morally correct work.

If the feedback from others is similar to the therapist´s self-concept, they tend to dwell less on it. For example, the patient says he/she appreciates one therapist´s empathetic reaction, which agrees with the therapist´s conviction that she is empathetic. However, if the feedback differs significantly from the therapist´s point of view, they may either use defence mechanisms to eliminate the dissonance or try to reflect on and change their behaviour. Self-reflection helps to use more adaptive ways of coping with these potentially conflicting situations. Quality knowledge of oneself disrupts the false image that the therapist may hold, such as self-admiration or, conversely, the tendency to see oneself in a worse light. It also helps to establish more realistic self-esteem.

The unreflected self-concept can be treacherous and fragile, quickly confronted in more complex situations in therapy and life. Therapist often gets into contradictory situations during their work. For this reason, quality self-experience can be a good anchor, a scale or a mirror on which the therapist can rely when solving complicated situations.

Few studies suggest using self-practice/self-reflection as an alternative to personal training-therapy in cognitive behavioural therapy training because of its promising results, and CBT therapists reported personal and professional benefits (Chigwedere *et al.* 2018; Chigwedere *et al.* 2021). Self-reflection as a routine practice could change CBT culture (Chigwedere 2019).

BENEFITS OF SELF-REFLECTION IN AND OUTSIDE THE THERAPEUTIC PROCESS

Self-experience in the therapeutic training process serves to get to know oneself about their attitudes, patterns of behaviour, problems, and mistakes, thus minimising their negative impact on their work. With self-reflection, the therapist can gradually detect and correct the mistakes in their actions and prevent them. A meta-analysis of qualitative studies examining therapists' self-experience in CBT by Gale & Schroder (2014) found that self-reflection allows therapists to understand clients better and experience the benefits and pitfalls of the client's experiences during treatment. The therapists reported increased self-confidence and a greater sense of therapeutic competence. The authors conclude that practising the CBT approach and reflecting on their own experiences can be an essential educational, valuable strategy for the therapist's continued development. Self-reflection can be especially useful for increasing empathy for clients and for recognising the difficulties they may encounter. In qualitative analyses of training feedback, we have observed several main benefits of self-experience:

(1) *Personal experience* with CBT allows a better understanding of what it is like to use a CBT

approach to manage one's problems or enhance personal growth. When the therapist deals with the client's problems, the experience gained from the practice is valuable. However, it does not offer an "insider view". Through their own experience with CBT strategies, the therapist learns about this approach from a new angle. They perceive the benefits of individual techniques and possible pitfalls. Thus, the therapist may find that careful time planning is complex for them to achieve. Another colleague may find that they use cognitive restructuring easily in some situations but forget that subjectivity of perception and cognitive errors exist in others. Self-experience can reveal that simple techniques are not so simple, while complex ones can become relatively easy.

(2) Easier *management of countertransference* – therapists who devote themselves to self-experience can better understand their clients through a greater understanding of themselves. This understanding can increase in several ways - one of them is the experience of individual approaches. Another way is to implement the individual approaches - a therapist who engages in cognitive work can more easily capture their cognitive error. In the end, the therapist can also gain a particular existential insight when they perceive each person has strengths and weaknesses, including themselves.

(3) *Creativity* - Increasing therapeutic experience can lead to the development of greater creativity at work. The therapist comprehensively learns about the "working tools" and, through their repeated use, can find other possibilities for their use or modifications to increase efficiency for different clients. This way, the longer-term use of CBT procedures in one's own life can increase therapeutic work creativity.

However, self-reflection is not just a thought process because cognitive processes are influenced by emotional states embedded in childhood experiences (Prasko *et al.* 2012a). Self-reflection requires a deeper understanding of one's own experience in the context of one's development. Self-knowledge can reveal shortcomings and limits of one's attitudes and behaviour patterns, which benefits the therapist. By exploring their inner world and realising their uniqueness, the therapist perceives others' uniqueness more. They stop projecting unconscious attitudes and qualities into them and learn to respect others more (Kunes 2009). Self-experience can therefore be necessary for:

- A deeper understanding of what is happening with the patient and the therapist in the current situation;
- A better understanding of the patient's life story;
- A greater understanding of the impacts of individual strategies;
- An understanding of one's transference and countertransference;
- Addressing the therapist's problems that interfere with the patient's treatment;
- Improving the quality of life of the therapist.

Self-reflection significantly influences a therapeutic relationship (Hoffart *et al.* 2002; Gilbert & Leahy 2007, Hardy *et al.* 2007). Awareness of one's inner experiences is an essential skill from which other skills, knowledge, and attitudes grow. These include awareness of the therapeutic role, recognition of transference and countertransference, emotional self-control, and continuous therapeutic competencies (Greenberg 2007, Praško *et al.* 2011).

Therapists who understand their internal processes well during sessions with clients can make better decisions, distinguish their own needs from the client's, understand transference and countertransference, and consider optimal response during a session (Leahy 2003, Orchowski *et al.* 2010). They can manage their feelings to suit the situation, their reactions follow the client's best interests, and their emotional expressions (Praško *et al.* 2012a). Knowing one's reactions becomes the basis for autonomy and knowledge of one's boundaries, regulating one's mood. Hoffart *et al.* (2006) examined how therapists' emotional responses to their agoraphobic patients are affected by the patient's personality disorder and his/her interpersonal behaviour problems and how it affects the treatment outcome. The severity of personality disorder was significantly related to feelings of insecurity among the therapists; Furthermore, the more insecure the therapist was, the worse the treatment outcome.

A study by Jennings & Skofholt (1999), which examined the personal characteristics of "masters of therapy", showed that reflectivity plays a crucial role in therapeutic functioning. These "masters" showed a thoughtful, open response without being defensive, even to negative feedback. A typical characteristic of these experts was a desire to learn and understand the ambivalent nature of their life experiences, and they used self-reflection in their personal and professional lives to better understand themselves and others.

Another essential benefit of self-reflection is related to burnout prevention. By practising self-reflection and self-monitoring is possible to recognise early signs s of burnout and act quickly. Mindfulness or meditation are two methods for developing self-awareness and self-reflection that some people find beneficial. Such practice can improve the capacity to monitor own feelings, thoughts, and behaviours during treatment sessions and between sessions (Norman *et al.* 2019).

In summary, self-reflection improves the procedural experience in the therapeutic process and the ability to continuously use one's emotions to understand better the therapeutic relationship (Safran & Muran 2000, Bennett-Lewy 2003). This continuous self-reflection is similar to mindfulness's inquisitive focus (Brown & Ryan 2003).

DEVELOPING SELF-REFLECTION

Bennett-Levy (2006), in his Declarative-Procedural-Reflective (DPR) model, provides a helpful insight into the conceptualisation of the development of therapeutic skills. This model distinguishes three information processing systems (Bennett-Levy 2006, Kyuken *et al.* 2009):

(1) The *declarative system* is based on the intellectual understanding of theoretical models and their practical implications (Anderson 2004). It is the knowledge of self-reflection, its meaning, how it can be practised, etc. This knowledge is the basis for other systems, but it presents only a theory that cannot provide quality therapeutic practice.
(2) The *procedural system* includes skills, attitudes, and behaviours in action. It is a practical competence and skill; this system is developed by training and practical experience with clients.
(3) The *reflective system* is the most important for developing skills (Bennett-Levy *et al.* 2009). Its importance grows in situations where the acquired declarative knowledge and procedural skills do not suffice because the current situation is complicated, the individual in therapy is resistant to a current approach or where significant transference and countertransference occur (Skovholt & Ronnestad 2001). This system is built mainly by supervision and regular practice of self-reflection.

The ability to self-reflect also encourages altruism and increases attunement to subtle manifestations of what others want or need (Rogers 1967; Goleman 1995). The development of self-reflection is particularly significant in light of Pope *et al.* (1987) study, which states that up to 60 % of clinical psychologists work with clients even when they feel uncomfortable and their work is ineffective. Practising attention to one's emotions and self-reflection can improve the ability to recognise one's discomfort and prevent a negative impact on clients (Vasquez 1992, Bennett-Levy *et al.* 2009). Culturally sensitive practice must be aware of how the client, supervisor, and supervisee's cultural, ethnic, or racial identities affect the therapeutic and supervisory relationship (Ramirez 1999).

Reflectivity is a term often used as a synonym for self-reflection. It is considered essential for developing critical thinking skills (McGlinn 2003, Mueler 2003, McAlpine *et al.* 1999). It is also used in medicine (Lyon and Brew 2003) and other health care professions (Billings & Kowalski 2006). A study of nearly 200 medical students showed that the introduction of continuous reflection was one of the essential components of their training, as it allowed them to increase their ability to learn other skills during didactic courses (Lyon & Brew 2003). Similarly, the practice of reflectivity in training professionals caring for and supervising individuals with mental disorders was tested (Kerry 2006, Ward & House 1998). The self-experience process usually leads to more reflections in the long-term process of understanding the self and the others, which helps the self-confirmation.

PROBLEMS WITH SELF-REFLECTION

When the therapist cannot realise their feelings, thoughts, or the influence of their attitudes in the therapeutic process, they can become defenceless towards them, might not control their behaviour to benefit the patient and himself/herself, and use compensatory or avoidant strategies of their own and patients' negative schemas (Leahy, 2007; Prasko *et al.* 2010). Therapists are often captivated by their emotions and cannot escape them. They usually do not realise their feelings or cognitive reactions; even if they do, they do it too late (Prasko *et al.* 2010). They are subject to their moods, often react with countertransference, or feel helpless in therapeutic situations (Young *et al.* 2003).

Some individuals struggle with self-reflection more than others. They do not like thinking about themselves, find it harder to complete their thought records or vicious circles, and have difficulty emotionally capturing them. This is often the result of mental avoidance (Prasko *et al.* 2012a). Deeper self-reflection could jeopardise thoughts and feelings that one would rather not have. For example, the therapist might find themself angry with others, feeling helpless, sad, or anxious. Their schemas tell them they should not have such thoughts and feelings and must reject them because they mean weakness or lead to rejection by others (Praško *et al.* 2009). This also applies to training therapists. However, blocks in self-reflection hinder the understanding of countertransference and may limit the ability to form a quality therapeutic relationship because the therapist is unaware of their role (Prasko *et al.* 2010).

SELF-EXPERIENCE AS A PART OF CBT TRAINING

Our CBT training in the Czech Republic, Slovakia, and Latvia included self-experience 15 years ago. That resulted from the Czech and Slovak Psychotherapeutic Society's demands that self-experience be required for a psychotherapy certificate. In the first years, students learned to identify their current problematic areas, map them, and then select one problem, which they systematically targeted problem-solving strategies supplemented by cognitive and behavioural techniques, including homework and change monitoring. Initially, they solved relatively simple problems, such as phobias, communication problems, mourning, study problems, procrastination, etc. In the last seven years, the self-experience work has been gradually more systematised and now includes current problem solving and early maladaptive schemas, modes, therapeutic letters,

imagery rescripting of adverse childhood experiences, or psychodramatic processing by working with chairs. The students also complete 30 hours of individual personal therapy. The self-experiential part of the training includes:

(a) Problem mapping

With the help of colleagues and training leaders, the student conceptualises their life problems. It consists of a developmental conceptualisation, understanding of one's formative influences, understanding the origin of core beliefs and schemas, conditional rules, and their influence on relationships, school/work, free time, and current problems. It also includes a cross-sectional conceptualisation with a vicious circle that maps the current triggers of problematic behaviour, automatic thoughts, bodily reactions, behavioural reactions, short-term and long-term consequences, and problem modulators, i.e. behavioural and functional analysis. The student then specifies the problem and sets the goals toward its solution.

When I started therapy, I often felt too much responsibility for patients. An experience with one patient stuck in my memory the most. He was a young man; his mother contacted me because she was worried about him and wanted someone to "finally" take care of him, cure him, and bring her relief. After the discussion with her, I was left with a strong feeling that I was obliged to start working with the patient more intensively, and at the same time, I felt the reluctance to do it. I also thought the patient would be too complicated for me, and I did not have the confidence to work with him. During supervision, I realised that I experienced similar feelings in adolescence when my parents and grandmother kept telling me that I had to supervise and watch out for my younger brother - I remembered specific experiences and rescribed some of them later in the course training. It helped me realise what thoughts and emotions I was experiencing in a similar situation. Although the patient did not continue therapy with me, a similar situation was repeated several times with different patients. However, these times I could communicate with their parents better. I still have a sense of responsibility for my patients, but it is more reasonable, and I can better realise when it affects me, inducing the feeling of reluctance and leading to my avoidant behaviour - for example, postponing sessions with patients.

(b) Problem-solving

After elaborating the conceptualisation, students focus on problem-solving, cognitive restructuring, activity planning, behavioural experiments, exposures, schema work, rescripting childhood and adult adverse events, mode dialogues, therapeutic letters, and social skills training.

Even before I started working in my first job, people around me were often praised for my ability to look at things "from the other side". When working with clients, especially when dealing with emotionally charged conflicts, I provide them with an objective view of the situation. We discussed the structure of the conflict, analysed the behaviour of both parties, considered what the other person might think, and created a suitable scenario – reflecting on what was said inappropriately, what was the core of the problem, and which words were spoken under the influence of emotions, and how further conflicts should be handled to avoid quarrels. I chose a similar procedure with my client Klara, who reported difficulties managing conflicts with her boyfriend. In the therapeutic environment, we always found an excellent solution to the situation and determined a suitable way of communication - but in practice, it usually did not work. Conflicts still turned out the same, and the client's inability to follow the planned scenario evoked feelings of guilt and inferiority in both of us. The client dealt with it with an increasing resignation. In my slight narcissism, I reasoned this by saying that the client does not have as deep an understanding of the other person as I do and tends to succumb to her emotions. I strived to interfere more with her life and save her but with no success. However, during the exercises within the CBT training and the subsequent self-experience in problem-solving, I realised that I have a problem with interpersonal relationships. People's conflicts, whether with me or with someone else, made me very anxious. My communication goal has always been to avoid conflicts at all costs.

Working in a group where we discussed our cognitive patterns, I revealed my dysfunctional emotional pattern - the belief that emotions are a sign of weakness, must not be "let loose", and must be kept under control. I realised that I demanded the same from my client - to have her emotions entirely under control and never allow her to communicate with her boyfriend when feeling emotional. Instead of expressing her needs, I tried to guide her to avoid all quarrels, which was neither beneficial nor feasible. After this discovery, Klara and I began to focus more on the assertive expression of her emotions and awareness of her own needs, not just a cold and impartial solution to conflicts. This led to significant relief for the patient - she realised that her goal was not to avoid arguing but for her boyfriend to understand and accept her emotions.

In the same way, I managed to establish a better therapeutic relationship with other clients, and I did not ask them to have their emotions under perfect control. Moreover, I planned other exposures to situations where I expressed my emotions. I soon felt more relaxed when experiencing emotions, whether my own or others, which alleviated my anxiety and made me feel happier in life.

SELF-EXPERIENCE AS A PART OF SUPERVISION

Self-reflection can be partly increased through supervision. However, we have to pay attention to the difference between supervision as such and self-experience. Even though personal issues are usually not primarily addressed during supervision, some improvement in understanding one's attitudes usually occurs.

Lucy (supervisee): I have a young woman in the ward, Miss K, who makes me feel angry. I know I should not feel like this, but I cannot help it. She is very demanding; she always asks for

something. When I show up in the hallway, she immediately has a request, complaining about something. Peter (a colleague of Lucie) has the same experience. I would like to know what to do to avoid getting so irritated by her because I feel I cannot help her much like this. When I talk to her alone, I lose my patience. I am unable to sincerely listen to her because she makes me feel mad so much. This usually does not happen to me; I have a good relationship with all the other patients.

George (supervisor): If I understand you correctly, you usually establish a good relationship with patients, but now you have a patient in the acute ward who frequently seeks you outside the sessions, irritating you. You are already losing patience with her, and you feel guilty and worry that you will not be able to help her. However, you would still like to help her if I understand well, even if you are angry with her. Is it so? *(The supervisor summarises what he has heard from the therapist, thus giving her a sense of acceptance - he listened well - and safety - he understands her).*

Lucy: Exactly…. The patient has a borderline personality disorder and annoys everyone, especially her family, with constant phone calls full of swearwords. On the other hand, she helps others and lends co-patients a mobile phone to call. She is committed to others and can be sensitive to them. I see that, too; she is not only wrong. Still, I feel like I am allergic to her. I cannot handle borderline patients. I understand she feels terrible, but why does she make others feel bad too? She cursed her mother on the phone, calling her "Bitch" and "Cunt", just because she forgot to bring her something. I do not mind vulgar words that much, but the mother is just trying to help her; after all, she comes to see her every day. Besides, she frightened other patients who now fear her. I do not have the patience for the borderline ones, and I am immediately mad at them. It is my fault. Peter does not feel that way; he better understands them. I do not. I would like to learn it somehow because it is clear that I currently do not help her. Then it dawns on me that I am a terrible doctor…. *(The therapist feels safe enough to speak openly. She is aware of various aspects of her relationship with the patient and begins with self-reflection.)*

George: You seem to think a lot about her when you realise that she annoys you and that she is committed to others and can be sensitive. Moreover, I understand it annoys you when she disrupts the whole department. In my experience, this type of patient can make most people feel upset. However, they tend to blame the patient for everything and do not think about themselves, like you. I find your attitude much more honest. You also want to change it and learn how to make her benefit more from the treatment. I like that you take an ethical approach *(The supervisor first reflects the conflict with the patient, then strengthens the safe atmosphere, empathises with the therapist, expresses understanding for her negative emotions, and normalises adverse reactions. After creating a safe atmosphere, he expresses appreciation for the ethical attitude and encourages and rewards the therapist's tendency to find a way to help the patient).*

Lucy: You are right; I see she is lovely, like when she helps others. I also do not want to be like everyone else and complain about how terrible the patients with BPD are —the most upsetting thing for me is the feeling that I cannot help her. When patients in mania swear and make a "mess", I am much kinder to them than to her. However, patients with bipolar disorder benefit from the drugs and calm down. While she is not significantly affected by the drugs and does not accept my psychotherapeutic attempts. She says that she has been seeing at least five experienced therapists and has been useless. She made it clear to me that I was young and inexperienced… If I could contact her and motivate her, maybe it would be better for us. I do not know if I could help her, but at least we could try. She rejects me while insisting on nonsense - for example. She changes the list of people to whom I can give information about her several times a day *(The therapist's self-opening continues.).*

George: I like the way you think about it. It can upset you when she rejects your therapeutic attempt while requiring your time for unimportant things. I like that you want to help her, even though she let you know you are not yet experienced. Can we try to think together about how to motivate her? What do you think? *(The supervisor supported the therapist again and reacted empathetically. He underlined one of the possible causes of problems in the relationship - the patient's devaluation of the therapist, but pointed to this in direct contrast to the therapist's desire to help).*

Lucy: Maybe she would accept if I talked to her about her childhood. When I took her history, I quickly went through it because I had little time. After all, she had been describing her current problems to me for a long time. I do not know much about her, except for her numerous conflicts with her father, boyfriend, and jobs. I know almost nothing about her upbringing. However, as I saw her dad, it certainly was not easy. Now I realise that I do not understand her much because I know little about her upbringing. Maybe she would like to discuss it *(The therapist realises that she does not have a complete conceptualisation of the case - which is one of the core competencies - because she does not know much about the patient's childhood. She feels safe and free to reflect).*

George: I see that you have already found one way to improve the therapeutic relationship with her and, simultaneously, to understand her more. It is possible that she had a problematic childhood… Do you think a sensitive discussion about childhood could help the patient feel more accepted? *(The supervisor encourages and confirms and uses an inductive question to indicate a possible schema-related problem of the patient).*

Lucie: Yeah, she keeps complaining that we all pay little attention to her. The staff, me, her family… My colleague paid little attention to her too… You are probably right; she does not feel accepted… She does not feel accepted anywhere. Likely, this is the topic in all of her conflicts… Well, and I cannot accept her either… It is hard… This is why she has to try to help others. Moreover, she gets so upset when someone does not pay enough attention to her *(The therapist develops the patient's hypothesis and core diagram, looking for evidence from the facts she already knows).*

Veronika (supervisee): My patient, Mr V, is depressed. He is not profoundly depressed, but the problem is that he does not do his homework at all. I always try to plan it with him as best I can; I discuss why and how he should do the task and ask about possible obstacles. He always gives up and does not do it. Each time he said to me at the next session, "You know, Doctor, I know I should do it, it is good for me, but then I always put it off, somehow I cannot bring myself to it. How do I force myself to do

it?" I have to explain to him why he cannot force himself. It seems that he is just lazy, and that is how he plays with me.

Karla (supervisor): Um, I understand that. You try to help him, you think about how to make it easier for him to handle it, you explain the meaning of the task and even ask about possible obstacles in the process, and he promises it all to you, and then he does not do the task and looks helpless. I am not surprised you are dissatisfied with this. Even seem a little upset *(The supervisor supports the therapist, gives positive feedback on the student's various specific homework competencies, and empathises with the occurring problems)*.

Veronika: Sometimes, I wonder if I should not skip his homework. I push him unnecessarily, and then I am just upset, and it does not matter in the end *(The therapist feels safe enough in a supervisory relationship to reveal her scepticism about continuing an essential part of the therapeutic plan.)*

Karla: It is possible… However, let us try to map out what is going on with the client before deciding. What makes him unable to do those tasks? What is stopping him? Does he have any attitudes or expectations that may be related to it? Does he believe he can handle it? Or does something else prevent it? Let us try to hypothesise schemas that may affect his behaviour and hinders this part of therapy *(The supervisor offers an alternative strategy that requires the therapist to use conceptualisation skills and specific competence to work with schemas in case of conceptualisation)*.

Veronika: I have already discussed it with him; I offered him the hypothesis that he may be prevented from doing so by some thoughts that activate when he wants to do homework and that it triggers his feelings of incompetence which also appear in other situations. When I asked him what he thought of it, he just said, "I do not know. You are an expert on that," and he got me again! *(The therapist tried to use conceptualisation to understand the client's non-cooperation but still felt blocked, there are also signs of countertransference.)*

Karla: What would you say about brainstorming everything we can think of and changing this situation? I want to say that I also have the experience when I ask some clients who are very avoidant or depressed why they do not do homework, they usually tell me that they "do not know" or that "they do not have the strength" or that "the homework would not help them anyway, "and then I feel for a moment the futility to work on it. The question is, what to do in such a situation? It occurs to me that we could look together to ask the client not to feel so guilty but more like an "expert" when answering. Maybe then we could figure out the reason. What do you think?

Veronika: You are right, I ask him why he did not do it, and he must feel as if a teacher was criticising him. I did not realise that. At the same time, his mother was a teacher who frequently asked him to do some tasks and continuously criticised him. I can act like that mother in his eyes though I hope I am not (laughs). He may feel helpless when he sits down to do the tasks. I did not discuss his feelings with him. I was expecting him to make excuses. I also did not discuss the thoughts that come to his mind when I give him homework. What happens to him when he promises to complete everything? Is he not afraid to tell me it is too much? Is he not afraid to admit when he does not understand something? When did he have such an experience with his mother? I hope we will find some way to encourage him more during the brainstorming. However, I have to admit that I seriously doubt myself when I have a session with him. Am I even able to do therapy? I am often impatient with him; sometimes, I do cognitive restructuring for him when he does not say anything, and then I comfort him when he says he is worthless and did not come up with anything himself. At times, I "save" him, but then I am annoyed that he did nothing himself, and he still uses it: "Look how incompetent I am." Then I feel helpless. It is clear to me that what I do is useless, that I cannot help anyone *(The therapist discovered some countertransference patterns in her reactions to the client, thus demonstrating the basic competence of self-awareness)*.

Karla: Very nice self-reflection! You surprised me with how good it is. Especially when I know you are only in your second year of training. Keep it up! You also asked some crucial questions straight away. What happens to the patient when he promises to complete the homework, and what happens when he gets to work on the homework? More detailed mapping of his thoughts, emotions, and behaviour in these situations could help him understand more. Maybe you could also deal with your doubts a little bit. Perhaps more balanced answers could be found that you could use to alleviate your doubts. I think you have what it takes to do the work well. *(The supervisor used the essential skill to build a supervisory relationship and strengthened the therapist's self-reflection. The supervisor also led the therapist to try a specific CBT skill - cognitive restructuring - to change her self-doubt regarding her therapeutic skills.)*

Veronika: Do you think I should say the pros and cons of my therapeutic work? (laughs) I mostly do good work, only sometimes, like now, I struggle with something. Then I unnecessarily feel like a failure. Fortunately, it always lasts a while; then, I overcome it. I tell myself that it is better to solve a problem than to ruminate about the mistakes. However, you are right; it is related to my attitudes towards myself which I should work on *(The therapist responds to the supervisor's support by mobilising her essential skill – a balanced reaction - and applies it to herself)*. I wonder if I should also record a session with Mr V so that you can see directly how I work with him? Would you have time to listen to it?

Karla: I would like to see a session recording with Mr V to give you more specific feedback. However, it is necessary to have his signed informed consent. It must also be clear to you that you are willing to expose yourself to such exposure and that we will listen together to what you are saying to the patient. However, I like the idea. It testifies to your courage and straightforwardness. These are qualities that I have noticed about you before *(The supervisor decided to work directly with the recording of the session, pointed out the ethical side of things, and appreciated the therapist for coming up with this idea)*.

The deepening of self-reflection takes place continuously during training and supervision. Therapists who use self-reflection frequently improve gradually. Self-reflection is essential to the growth of supervisors' clinical skills (Sutton *et al.* 2007). Therefore, supervisors need to strengthen their ability to self-reflect. Unfortunately, supervisors sometimes automatically focus on the technical components of the therapy

they are trying to evaluate and forget the importance of the supervisor's self-reflection. However, it seems evident that if the supervisors do not pay enough attention to the supervisee's self-reflection during the supervision, the supervisee might keep misunderstanding the client, and therapy might fail (Bernard & Goodyear 2004). No matter how trained, all supervisors can benefit from a greater focus on self-reflection (Orchowski *et al.* 2010).

I worked with my problem as part of the supervision in small groups in the third year of training. We had an older woman addicted to alcohol in the psychotherapeutic department. At the beginning of her hospitalisation, she even developed withdrawal syndrome. When I opened this topic during individual planning, she was verbally aggressive and denied all the symptoms and the addiction. I tried to prove that and showed her that the objective examination methods (laboratory samples, the clinical signs) were correct and that she should be treated for her addiction. In retrospect, I realised that I had pushed her too hard and was not restrained. The situation resulted in her prematurely leaving the psychotherapeutic program.

I blamed myself for it, so I took her case to supervision. Through a group-guided discovery, I realised the countertransference that comes from my grandmother. She has been addicted to alcohol all her life, with better and worse periods. She was treated for the addiction several times but eventually started drinking again. She was very kind to us when we were children; in the summer, she took us to the cottage with our grandfather and cared for us. However, when she drank, she became different and sometimes aggressive. I became aware of many childhood experiences I had and did not understand due to alcohol.

I also realised that I have this transference in more women struggling with alcohol addiction in supervision. While working with the ideas, I discovered my feelings of helplessness, and, according to the supervisor's recommendation, I continued to work with my core beliefs and wrote a description of my childhood experiences. My colleague and I reflected on this during further training, and thanks to this experience, I could work with my countertransference. Women with alcohol addiction no longer evoke such strong emotions in me, and I can persuade them to cooperate in addiction treatment by mapping the vicious circle and motivational conversation.

In the supervision process, self-reflection occurs during the supervisor-to-supervisee dialogue, trying to understand the supervisee's emotional response in a particular therapeutic situation or relationship based on how the supervised individual understands the situation (Overholser 1991, Beck *et al.* 2008). Self-reflection can be a new understanding of the situation and a new response used in the therapy. In a quantitative study of more than 100 mental health professionals in five stages of their professional growth, Skofholt & Ronnestad (1992) found that continuous professional reflection training can be essential for professional maturation. Besides, therapists who have incorporated reflective attitudes into their clinical practice can create a supportive and open professional environment and often discuss their practice with their colleagues. In contrast, individuals who do not use self-reflection often show insufficient and fragmented professional development.

Recordings of therapeutic or supervisory sessions might improve the ability to self-reflect (Linehan *et al.* 1994, Swales & Heard 2009). Getting feedback by watching a recording can clearly show the use of self-reflection. E.g., therapists avoid showing their vulnerability or reducing their anxiety and insecurity levels by avoiding discussing sensitive topics (Kadushin 1976). Therapists avoid self-reflection, especially when they are hypersensitive or insensitive to criticism or afraid to show their vulnerability, question their therapeutic skills, and admit that they also do not know something or are unsure (Powers 1989, Bennett- Levy & Beedie 2007). Advice or frequent psychoeducation instead of discussing personal experiences may signify that the therapist avoids critical self-reflection (Hahn 2001). Procedures similar to practising self-reflection in patients can enhance therapists' self-reflection: recording vicious circles, automatic thoughts, and working on cognitive schemas related to countertransference.

If it is helpful for therapy, the supervisor can also be a model for the therapist to reflect on their own deeper attitudes. At the beginning of supervision, the supervisee is usually tense, uncertain about his/her therapeutic role, and anxious. However, he/she is usually highly motivated to do the best he/she can (Hawkins & Shohet, 2000). New trainees may be concerned about the supervisor's view of their work, fear criticism over whether they are worse or better than other therapists, etc...

At the beginning of the supervisory relationship, the supervisor must emphasise self-reflection and set an example. The self-reflection importance can be underlined already in the supervision contract, during which the supervisor discusses with the supervisee the motivation and expectations from supervision (Bernard & Goodyear 2004).

Watkins (1995) emphasises that the more experienced a supervisor is, the more self-reflection he/she uses in his supervision and speaks openly about his/her experience during supervision, which helps the supervisee follow a similar path. Similarly, Dunne (1994) argues that supervisors must perform their self-reflection to learn to reflect well, which is essential for passing the knowledge to supervisees. (Bernard & Goodyear 2004; Ramirez 1999).

SELF-REFLECTION TECHNIQUES

Self-reflection increases during therapeutic training and supervision (Machado *et al.* 1999, Milne 2008). The therapists can practice self-reflection using classical

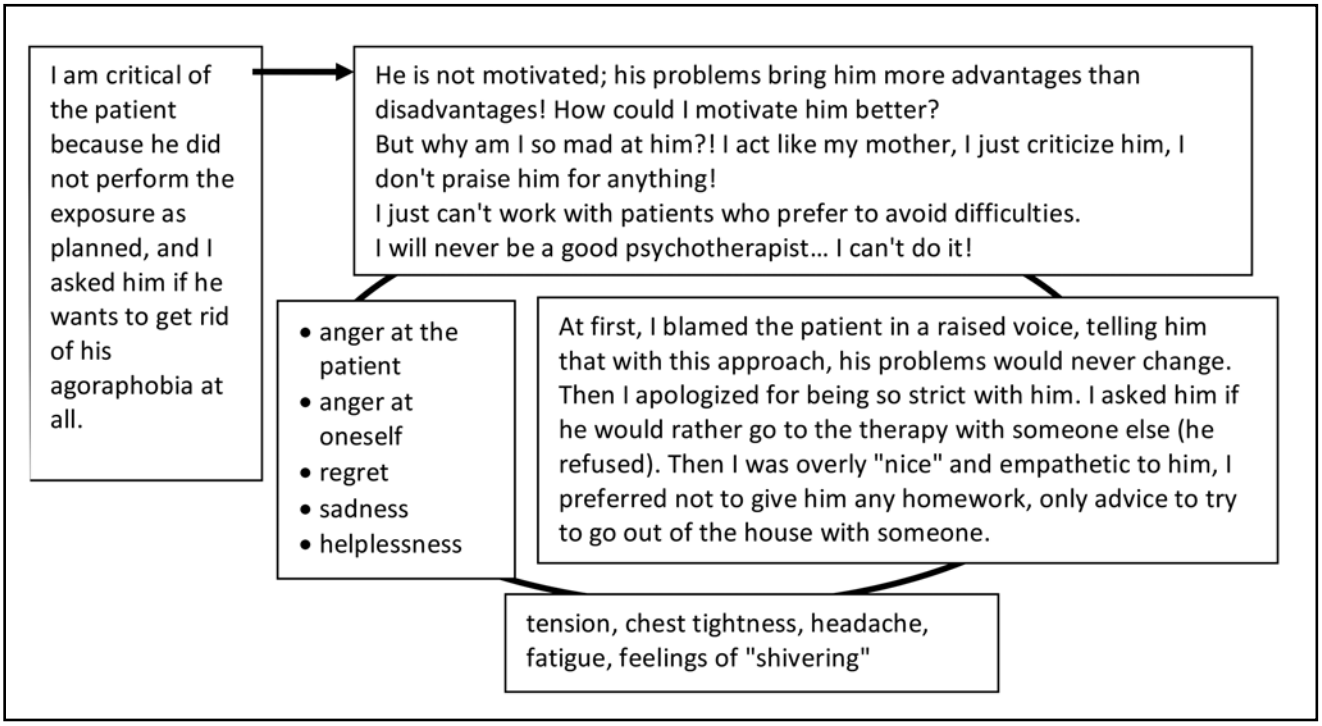

Fig. 1. A vicious circle of reactions to a patient during a therapy session

cognitive-behavioural therapy techniques or taught during supervision (Laireiter & Willutzki 2003). For self-reflection, the student uses the same techniques used with clients. They can work with them independently when processing their own experience in personal life when working with clients or in therapy, where they are led either by another student in skills training or by a therapist in personal therapy. The most common CBT strategies for developing self-experience and self-reflection are:

(1) The vicious circle of the problem
(2) Setting problems and goals
(3) Cognitive restructuring of automatic thoughts and meta-cognition
(4) Activity planning
(5) Exposure therapy
(6) Work with core beliefs, schemas and conditional assumptions
(7) Mode work
(8) Imagery rescripting of adverse childhood and adulthood experiences
(9) Psychodramatic work – for example, chair or toy work presenting modes
(10) Therapeutic letters
(11) Problem-solving
(12) Social skills and assertiveness training

The above strategies in individual therapy usually focus on the patient´s problems, but it is possible to use many of these strategies to solve problematic situations within the supervision. E.g., it is possible to use a vicious circle to map their reactions to the patient (Prasko *et al.* 2012a).

Another option is to regularly record automatic thoughts after a session when the therapist has time to consider what was happening in them and what they want, why they react emotionally in a certain way and why they behave differently. Another possibility is to immerse in the diagrams using the downward arrow technique to gain a more in-depth understanding of the thoughts, emotions, and behaviour (Prasko *et al.* 2012a).

It is also possible to write down thoughts during a therapy session or watch an audio or video recording session with a patient. Recording initially raises concerns among supervisees because they are unsure of their skills, afraid of negative comments from others, or even seeing themselves on the recording (Hawkins & Shohet 2000). During supervision, however, supervisees usually calm down and forget about the camera after a few recordings. If the supervision is safe, encouraging, and respectful, the joint analysis of the recordings does not make them feel uncomfortable for too long (Praško *et al.* 2011), but on the contrary, they often welcome it because it allows them to remember better what happened during the session.

CONCLUSION

Self-reflection and self-experience using the CBT approach can be essential in the therapists' training and clinical practice. Self-reflection helps to increase the understanding of the patients' conceptualisation during therapy. Moreover, the dynamics of the therapist's development during therapy – self-experience and

appropriate self-reflection, help to increase the therapist's self-confidence and skills.

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