Open Access

OBM Integrative and Complementary Medicine

LIDSEN Publishing Inc.

Original Research

Exploring the Impact of Genuineness in Psychotherapy: A Self-Practice/Self-Reflection (SP/SR) Report

Candice Fischer [1, *], Carolina Eugenia Cáceres-Videla [2]

1. Pontificia Universidad Católica de Chile, Santiago, Chile; E-Mail: cfischer@uc.cl
2. Coventry University, Coventry, UK; E-Mail: wagnerc@uni.coventry.ac.uk

* **Correspondence:** Candice Fischer; E-Mail: cfischer@uc.cl

Academic Editor: Robert Marx

Special Issue: The Personal and the Professional: Mindfulness, Spiritual Life and Health Care

OBM Integrative and Complementary Medicine
2024, volume 9, issue 3
doi:10.21926/obm.icm.2403046

Received: March 21, 2024
Accepted: August 01, 2024
Published: August 12, 2024

Abstract

A growing body of evidence has highlighted the limitations of relying solely on positivist research when summarizing SP/SR results since it might hinder pluralistic perspectives from unique backgrounds and life experiences. In the present reflective report, I aim to conduct quantitative and qualitative research on myself to explore the impact of concentrating on genuineness when delivering psychotherapy as a trainee. This article provides concrete examples of how therapists' authenticity could benefit the therapeutic alliance. The therapist completed the 15-item five-facet mindfulness questionnaire, the Center for Clinical Interventions' assertiveness questionnaire, the authenticity scale, and the values in action inventory. Clients filled out the working alliance inventory-short, revised version during mid-treatment reviews. Thematic content analysis was applied to the 3000-word written reflective report submitted for assessment as part of the training. The management of difficult emotions coupled with the development of compassion, a practice that promotes EDI, and a cohesive sense of self were some of the benefits I experienced. Emotional awareness is emphasized as the first step towards authenticity, which I facilitated through regular mindfulness practice.

Regarding compassion and a paced approach, issues might arise in services requiring outcome measurements to be reduced to the point of recovery by the end of the treatment. The study approaches authenticity as a value constantly pursued in a continuously evolving ideal self. A life of committed professional improvement and practice is warranted, where maintaining authenticity requires ongoing therapist reflection.

Keywords
Genuineness; mindfulness; MBCT; cognitive behavioural therapy; CBT; psychodynamic therapy; reflection; SP/SR

1. Background

Personal practice (PP) of therapeutic techniques for personal and professional growth during psychotherapy training has been a standard expectation of counseling training [1, 2]. However, cognitive behavioral therapies' (CBT) training focuses on theoretical conceptualizations, the implementation of outcome measurements, and evidence-based interventions without a mandatory requirement of PP [3]. Notwithstanding, in the last two decades, research has highlighted the value of PP in the form of self-practice/self-reflection (SP/SR) [4]. The main content and sub-content of "*Experiencing CBT form the Inside Out: A SP/SR Workbook for Therapists*" is summarized in Table 1 [5]. SP/SR in one-year CBT training requires an introductory session led by qualified therapists to answer questions, instruct trainees to create a safety plan, and set group rules for 12 facilitated small group sessions spread across the year [5]. By the end of the training, submitting a reflective report is a qualification requisite.

Table 1 Main content and sub-content of "Experiencing CBT from the Inside Out: A SP/SR Workbook for Therapists" [5].

Chapters	Main content	Sub-contents summary
Module 1	Identifying a Challenging Problem	Visual Analogue Scale (VAS)
Module 2	Formulating the Problem and Preparing for Change	Exploring Cultural Identity: ADDRESSING Profile Developing a Problem Statement Strengths-based Formulation Setting SMART Goals
Module 3	Using Behavioural Action to Change Patterns of Behaviour	Activity and Mood Diary Scheduling Pleasurable and Necessary Activities
Module 4	Identifying Unhelpful Thinking and Behaviour	Identifying Negative Automatic Thoughts (NATs) Common Cognitive Biases Selective Attention Avoidance and Escape Behaviours Safety Behaviours Unhelpful Repetitive Thinking
Module 5	Using Cognitive Techniques to Modify Unhelpful Thinking and Behaviour	Socratic questions
Module 6	Reviewing Progress	Goal Review Roadblocks to Progress

		Problem Solving
Module 7	Identifying Unhelpful Assumptions and Constructing New Alternatives	Identifying Recurring Personal Themes and Most Unhelpful Assumption Creating a New Alternative Assumption
Module 8	Using Behavioural Experiments to Test Unhelpful Assumptions against New Alternatives	Planning Behavioural Experiments Creating Follow-Up Experiments
Module 9	Constructing New Ways of Being	Summary Statement New Ways of Being Record Book
Module 10	Embodying New Ways of Being	Record Book Review Stories with New Ways of Being Qualities Re-experiencing the Stories in Imagination Adding Music and Body Movement to the Story Anticipating Potential Problems Ideas or Rules to Address Potential Problems
Module 11	Using Behavioural Experiments to Test and Strengthen New Ways of Being	Creating a Summary Image, Metaphor, or Drawing
Module 12	Maintaining and Enhancing New Ways of Being	Reviewing Old Ways of Being/New Ways of Being

A growing body of evidence has highlighted the limitations of relying solely on positivist research when summarizing SP/SR results since it might hinder pluralistic perspectives arising from unique backgrounds and life experiences [6]. Autoethnography, an approach to qualitative research aiming to systematically review personal experiences in the context of cultural identity in retrospect, has been proposed as a solution [7, 8]. Critical features to understanding autoethnography are: The researcher also takes part in the process as a participant, and there is narrative visibility of the researcher's self. Therefore, the present personal case study of SP/SR draws upon autoethnography to explore my experience while completing the one-year training.

To acknowledge feedback from previous supervisors, I decided to concentrate on the impact of genuineness when delivering psychotherapy. Beyond my motives, therapists' authenticity has been historically put forward in CBT due to its advantages on building a solid therapeutic alliance (TA) [9]. Its relevance has been addressed in the Cognitive Therapy Scale (CTS-R) and The Mindfulness-Based Interventions-Teaching Assessment Criteria MBI: TAC [10, 11]. The CTS-R and the MBI: TAC consider authenticity an integral relational skill to be developed and maintained by psychotherapists at all stages of their training.

1.1 Rationale

As previously stated, acknowledging the role of genuineness in the person of the psychotherapist can expand on previous studies and inform clinicians' practice by protecting the TA [9-11]. Secondly, SP/SR can be applied remotely, an expanding modality since the COVID-19 pandemic, which requires isolation as a public health measure [12]. Since one psychotherapist can conduct SP/SR remotely with fellow practitioners, its implementation might positively influence the provision of affordable interventions to prevent burnout by supporting well-being and resilience [13].

1.2 Objectives

In the present reflective report, I aim to conduct quantitative and qualitative research on myself to explore the impact of concentrating on genuineness when delivering psychotherapy as a trainee. This article provides concrete examples of how therapists' authenticity could benefit the TA.

2. Methods

2.1 Participants

The case study focuses on my experience, which emerged from conducting SP/SR while completing a Postgraduate Diploma in CBT. At that time, I met the British Association for Behavioural and Cognitive Psychotherapies (BABCP) "*Knowledge, Skills and Attitudes*" (KSA) criteria via other relevant vocational and training experiences. The clients consented to anonymizing their data for research and publication while completing an initial therapy contract.

2.2 Measures

Outcome measurements were implemented twice, at the beginning and end of SP/SR, to set clearer goals and monitor and inform the discussion. The process did not involve statistical analysis. The therapist completed the following questionnaires: 15-item five-facet mindfulness questionnaire (FFMQ-15), the Center for Clinical Interventions' assertiveness questionnaire, the authenticity scale, and the values in action (VIA) inventory [14-17]. Conversely, the working alliance inventory-short, revised version (WAI-SR-C) [18] was filled out by clients during mid-treatment reviews.

2.3 Data Analysis

Thematic content analysis (TCA) was applied to the 3000-word written reflective report submitted for assessment during the training [19]. This written report conveyed (1) what I had learned about myself and (2) how I related this personal learning to my clinical practice. Its findings were derived from SP/SR, an emotional avoidance formulation diagram, assertiveness training modules, attending personal psychoanalysis once per week, and mindfulness [5, 15, 20].

Once completed, the report was extensively reviewed and inputted by one personality and mindfulness expert to ensure the supporting theories' fidelity. I invited this expert to collaborate as a second author of the paper in line with Bennett-Levy et al. [5]'s suggestion of incorporating cultural role models that strengthen new ways of being through embodiment. Autoethnographically, this Associate Professor played a crucial role in my career development by providing feedback, extending opportunities to collaborate with her in research, supporting my application to postgraduate studies, and introducing me to mindfulness.

3. Results

3.1 Emotional Awareness, Acceptance, and Expression

For specific monitoring, I completed the FFMQ-15 (2006), where items that required improvement were: "*I think some of my emotions are bad or inappropriate, and I should not feel them*" and, "*I tell myself I should not be feeling the way I am*" [14]. Accordingly, it led me to set goals

related to emotional acceptance, which was a pivotal step in the process. Emotional acceptance collaborated with a contemplative approach to the feelings remaining after each client's interaction, leaving enough time after each session for record keeping and reflection. Gibbs's [21] model of reflection facilitated the assimilation of unpleasant emotions to attend supervision before the client's next session. Unpleasant emotions often lead to points for professional development. For instance, the points for improvement stated by the clients were demonstrating more appreciation for their homework completion and setting more explicit session goals [18]. On the other hand, I felt more at ease when I kept diagnostic levels at the assessment stage to be a horizontal facilitator in the sessions. Additionally, from abstract conceptualization, it became clear that I needed to integrate other theoretical approaches to make sense of therapeutic experiences [21].

As an illustration, I present a vignette from a personal reflection produced during the assertiveness training. In this excerpt, I elicit frustration in the interaction with one of my clients, who I will call SP, and analyze the experience in the light of psychodynamic concepts. At the time of the assessment, SP was a 27-year-old female, single without offspring, employed full-time. Her symptoms were indicative of a recurrent depressive disorder, and her goals pointed toward improving her self-esteem and interpersonal relationships.

> "*At that moment in time, I did not know what I found exactly triggering about my sessions with her. SP was not diagnosed with a personality disorder. Still, other factors which have been related to perceiving a patient as difficult were present, such as a past challenging life context, interpersonal difficulties, self-destructive behaviour, and emotional dysregulation [22]. Contrarily, SP presented the following protective factors in our therapeutic alliance: Ability to form close relationships and her attitude towards the treatment, the NHS in England, and myself [22]. Supervision of our session's recordings did not help me to engage her with the structure required for CBT. Although SP did attend promptly and prepared, our sessions hardly went as planned, and I was left with an unsteady sensation after speaking with her. The process report touched on several areas that had not been explored by me until that point. Among them, I could mention issues with eliciting emotions, where SP would prefer narrating her dreams, which occurred often during the treatment. From a personal perspective, I also experienced parapraxis or behavioral slips whilst writing her process report, where I unconsciously wrote the assignment in the third person [23]. Thus, I realized that our interaction needed further growth on my part to be able to fulfill her needs. Despite these obstacles, she acknowledged my feedback when I expressed my feelings towards our progress".*

In view of the learning points, I paid particular attention to my emotions in the sessions when the clients reported symptoms of depression and interpersonal difficulties. As the experiences presented could be indicative of emotional avoidance in both the client and the therapist, I enhanced my emotional awareness, acceptance, and expression.

3.2 Approaching Psychotherapy as a Process of Compassionate Research

Experiencing questionnaires, formulations, goal monitoring, and interventions from the inside out gave me added empathy toward service users [13]. Due to the challenges of SP/SR, I was keener on approaching therapy as a recursive process of qualitative research that was specified by quantitative measurements [24]. From a personal viewpoint, reading and answering the questionnaires to gain awareness initially came as a negative experience of boredom and frustration.

Hence, I became compassionate towards clients' avoidance and gently prompted them to complete them when needed. In addition, I discussed with them the benefits of keeping a record to remember their baseline and overcome selective attention to the negative by the end of the treatment. For example, some clients experiencing symptoms related to perfectionism or low self-esteem usually did not feel entitled to reward themselves for their progress and tended to perceive it as "*not enough*".

3.3 Cultural Awareness as the First Step in Equality, Diversity, and Inclusion (EDI)

Coming from Chile, in Latin America, and having recently moved to the United Kingdom (UK), I consequently went into studying my own five-part CBT formulation informed by cultural factors [25]. Therefore, I used culturally informed formulations when clients were going through acculturation to aid their adjustment. Moreover, I delved into relational reflexivity to visualize how our similarities and differences played out in the sessions [26]. In addition, I borrowed the following questions from our lecturer on EDI: "*What do you think is characteristic of your culture? Do you identify yourself with those characteristics? If yes, what aspects are helpful or unhelpful?"* And finally, *"What is the relationship to help in your culture?"* [27].

Delving into EDI, I began to consider client's religion in their formulations and as a coping mechanism by being part of a community, among other resources derived from their spirituality [28, 29]. For instance, in the case of obsessive-compulsive disorder (OCD), the Qur'an, as a spiritual text, acted as a source of positive statements to encourage treatment engagement [30]. In addition, awareness of the dates of cultural events was crucial so that behavioral experiments were not placed during periods of celebration or abstinence, such as Ramadan. From the therapist's perspective, I used my Latino cultural characteristics to enhance emotional expression through non-verbal communication and elicit emotions [31].

3.4 A Cohesive Self Across Personal and Professional Domains

By increasing my awareness of who I am, I could appreciate that my personal self and therapist self were intertwined, although I had tried to separate them. I used to believe this would help me to set healthy boundaries and prevent burnout, but it ultimately led me to an unpleasant feeling tone in the sessions. As a result of the insight, I opted to wear different hats without aiming to divide myself. This integration ultimately helped me to reduce uncomfortable bodily sensations and led me to a more Socratic approach in my overall interactions. On the other hand, I experienced the satisfaction of combining my passion for mental health, activities I share with significant others, and hobbies.

4. Discussion

4.1 Implications for Practice

The management of difficult emotions coupled with the development of compassion, a practice that promotes EDI, and a cohesive sense of self were some of the benefits I experienced from concentrating on genuineness when delivering psychotherapy. Thus, similarities can be found with benefits recently proposed by Presley & Jones [32], who emphasize professional development through enhanced TA skills and attending to emotional experiences. Differences might be related

to the specific SP/SR topic, additional steps added to Bennett-Levy's [5] methodology, personal values, and being a dual citizen.

This study emphasizes emotional awareness as the first step towards authenticity, which regular mindfulness sessions can facilitate. As proposed by other supporters of the use of mindfulness, its practice promoted my abstract thinking [33]. The previous might be particularly relevant when feedback from the client and psychotherapist appeared contradictory. Thus, integration is required before responding [21]. For instance, clients might ask the facilitator to lead in setting the agenda for each session while the practitioner is attempting to collaborate. Here, meta-competence development might require the therapist to adapt their style in response to the patient while maintaining guided discovery [34].

With regard to compassion and a paced approach, issues might arise in services requiring outcome measurements to be reduced to the point of recovery by the end of the treatment. Because qualitative information provided by clients can be time-consuming for service managers to monitor progress, changes in work and social adjustment may be considered in addition to general and specific outcome measurements [35].

4.2 Recommendations for Future Research

Methodologically, future studies on the role of genuineness might be enhanced by conducting a systematic literature review and applying a standardized protocol based on the methods gathered. Although I followed Bennett-Levy et al. [5] steps, it seemed that the topic of genuineness required additional input. It would be beneficial to explore whether this methodology could be applied to a representative sample of trainees or qualified psychotherapists in which research could be conducted. Nonetheless, it is worth mentioning that since TCA focuses on looking for patterns across written accounts, phenomena that occur in only one individual can be overlooked, thus the richness of the present study. Another significant limitation is the challenge that an author analyzing its work represents in terms of objectivity, which was minimized by including a mentor reviewer, who acted as an external observer. Finally, it is worth mentioning that the report did not cover setbacks encountered nor detrimental effects that might appear in the therapeutic alliance, thus being a point for further research.

The research paper's uniqueness is one of its strengths since it appears to be the first published attempt to investigate the effects of genuineness through SP/SR. It demonstrates how therapists can enhance their CBT personal and professional practice using autoethnographic principles. Additionally, it considers the model's limitations, where an event has been theorized following psychodynamic principles.

5. Conclusion

The study approaches authenticity as a value constantly pursued in a continuously evolving ideal self [36]. Due to the dynamic nature of psychotherapy, there is a need for continuous learning and growth to adapt to the changing needs of clients and the advances in the field. To summarize, although an introduction to CBT competencies can be grasped during a one-year training, a life of committed professional improvement and practice is warranted, where maintaining authenticity requires ongoing reflection from therapists.

Acknowledgments

We extend our appreciation to Coventry University for including self-practice in cognitive behavioral therapists' training. Particularly, we thank Gwion Jones from the Center of Freudian Analysis and Research (CFAR). This article might not have been possible without the inspiration brought by him to Friday morning lectures on EDI and reflective practice.

Author Contributions

Carolina Eugenia Cáceres-Videla: Conceptualization, methodology, analysis, and writing - Original draft. Candice Fischer: Writing – Review & editing. Both authors have read and approved the published version of the manuscript.

Competing Interests

The authors have declared that no competing interests exist.

References

1. British Psychoanalytic Council. Psychoanalytic psychotherapy accreditation criteria [Internet]. London, UK: British Psychoanalytic Council; 2022. Available from: https://www.bpc.org.uk/download/6347/Psychoanalytic-Psychotherapy-Training-Criteria-Revised-May-2022.pdf.
2. British Psychological Society. Qualification in counselling psychology: Handbook for Candidates [Internet]. London, UK: British Psychological Society; 2022. Available from: https://cms.bps.org.uk/sites/default/files/2022-07/QCoP%20Candidate%20Handbook.pdf.
3. Leahy RL. The therapeutic relationship in cognitive-behavioral therapy. Behav Cogn Psychother. 2008; 36: 769-777.
4. Scott J, Yap K, Bunch K, Haarhoff B, Perry H, Bennett-Levy J. Should personal practice be part of cognitive behaviour therapy training? Results from two self-practice/self-reflection cohort control pilot studies. Clin Psychol Psychother. 2021; 28: 150-158.
5. Bennett-Levy J, Thwaites R, Haarhoff B, Perry H. Experiencing CBT from the inside out: A self-practice/self-reflection workbook for therapists. New York and London: Guilford Publications; 2015.
6. Chigwedere C. Writing the 'self' into self-practice/self-reflection (SP/SR) in CBT: Learning from autoethnography. Cognit Behav Ther. 2019; 12: e38.
7. Denshire S. Autoethnography [Internet]. Madrid, Spain: Sociopedia.isa; 2013. Available from: https://sociopedia.isaportal.org/resources/resource/autoethnography/download/.
8. Ellis C, Adams TE, Bochner AP. Autoethnography: An overview. Forum Qual Sozialforsch. 2011; 12: 10.
9. Leahy RL. Schematic mismatch in the therapeutic relationship: A social-cognitive model. In: The therapeutic relationship in the cognitive behavioral psychotherapies. London, UK: Routledge; 2007. pp. 229-254.
10. Blackburn IM, James IA, Milne DL, Baker C, Standart S, Garland A, et al. The revised cognitive therapy scale (CTS-R): Psychometric properties. Behav Cogn Psychother. 2001; 29: 431-446.

11. Crane RS, Eames C, Kuyken W, Hastings RP, Williams JMG, Bartley T, et al. Development and validation of the mindfulness-based interventions-teaching assessment criteria (MBI: TAC). Assessment. 2013; 20: 681-688.
12. World Health Organization. Listings of WHO's response to COVID-19 [Internet]. Geneva, Switzerland: World Health Organization; 2020. Available from: https://www.who.int/news/item/29-06-2020-covidtimeline.
13. Mösler T, Poppek S, Leonhard C, Collet W. Reflective skills, empathy, wellbeing, and resilience in cognitive-behavior therapy trainees participating in mindfulness-based self-practice/self-reflection. Psychol Rep. 2023; 126: 2648-2668.
14. Baer RA, Smith GT, Hopkins J, Krietemeyer J, Toney L. Using self-report assessment methods to explore facets of mindfulness. Assessment. 2006; 13: 27-45.
15. Center for Clinical Interventions. Assert yourself! [Internet]. Northbridge, Australia: Center for Clinical Interventions; 2019. Available from: https://www.cci.health.wa.gov.au/~/media/CCI/Consumer-Modules/Assert-Yourself/Assert-Yourself---01---What-is-Assertiveness.pdf.
16. Kernis MH, Goldman BM. A multicomponent conceptualization of authenticity: Theory and research. Adv Exp Soc Psychol. 2006; 38: 283-357.
17. Peterson C, Seligman ME. Character strengths and virtues: A handbook and classification. New York, NY: Oxford University Press; 2004.
18. Munder T, Wilmers F, Leonhart R, Linster HW, Barth J. Working alliance inventory-short revised (WAI-SR): Psychometric properties in outpatients and inpatients. Clin Psychol Psychother. 2010; 17: 231-239.
19. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006; 3: 77-101.
20. Presley VL, Jones G, Marczak M. The relationship between therapist experiential avoidance and observed CBT competence during training: A preliminary investigation. Cogn Behav Ther. 2023; 16: e15.
21. Gibbs G. Learning by doing: A guide to teaching and learning methods. Oxford, UK: Further Education Unit, Oxford Polytechnic; 1988.
22. Fischer C, Cottin M, Behn A, Errázuriz P, Díaz R. What makes a difficult patient so difficult? Examining the therapist's experience beyond patient characteristics. J Clin Psychol. 2019; 75: 898-911.
23. Poscheschnik G, Crepaldi G. Only chance and circumstances? Or, how Freudian are Freudian slips? A review of research literature concerning parapraxes. Psychol Psychol. 2022; 39: 189-197.
24. Glaser B, Strauss A. The discovery of grounded theory: Strategies for qualitative research. Chicago, IL: Aldine; 1967.
25. Hays PA. Integrating evidence-based practice, cognitive-behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. Prof Psychol Res Pr. 2009; 40: 354-360.
26. Burnham J. Developments in social GRRRAAACCEEESSS: Visible-invisible and voiced-unvoiced. In: Culture and reflexivity in systemic psychotherapy. London, UK: Routledge; 2013. pp. 139-162.
27. Reder P, Fredman G. The relationship to help: Interacting beliefs about the treatment process. Clin Child Psychol Psychiatry. 1996; 1: 457-467.
28. Steketee G. Treatment of obsessive compulsive disorder. New York, NY: Guilford Press; 1993.

29. National Institute for Health and Care Excellence. Obsessive-compulsive disorder and body dysmorphic disorder: Treatment: Clinical guideline [CG31] [Internet]. London, UK: National Institute for Health and Care Excellence; 2005. Available from: https://www.nice.org.uk/guidance/cg31.
30. Abdel-Haleem M. The Qur'an: A new translation. Oxford, UK: Oxford University Press; 2008.
31. Rimondini M. Communication in cognitive behavioral therapy. New York, NY: Springer Science & Business Media; 2011.
32. Presley VL, Jones G. 'Crossing the reflective bridge': How therapists synthesise personal and professional development from self-practice/self-reflection during CBT training. Cogn Behav Ther. 2024; 17: e18.
33. Škobalj E. Mindfulness and critical thinking: Why should mindfulness be the foundation of the educational process? Univers J Educ Res. 2018; 6: 1365-1372.
34. Roth A, Pilling S. The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorder. London, UK: Department of Health London; 2007.
35. Mundt JC, Marks IM, Shear MK, Greist JM. The work and social adjustment scale: A simple measure of impairment in functioning. Br J Psychiatry. 2002; 180: 461-464.
36. Rogers CR. The necessary and sufficient conditions of therapeutic personality change. J Consult Psychol. 1957; 21: 95-103.