

# Self-practice/self-reflection (SP/SR) as a training strategy to enhance therapeutic empathy in low intensity CBT practitioners

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Low intensity CBT interventions are starting to be introduced into national healthcare systems (e.g. UK, Australia) to facilitate population-wide access to evidence-based psychological interventions. Good practitioner interpersonal skills are important to enhance the effectiveness of low intensity interventions. Self-Practice/Self-reflection (SP/SR) is an experiential training strategy with an evidence base that suggests its value in enhancing interpersonal skills. This study examines the impact of SP/SR on therapeutic empathy in a group of experienced low intensity practitioners in England. The results suggest a primary impact of SP/SR on practitioners' empathic stance/attitude. Other aspects of empathy (empathic attunement, empathic communication) are potentially responsive to SP/SR, but may require skilled reflective questioning and deliberate practice to translate attitude/stance to empathic attunement and communication skills.

## Introduction

Low intensity interventions have been developed as a population-wide strategy to increase access to evidence-based psychological therapies, using the minimum level of intervention necessary to create the maximum gain (Bennett-Levy et al., 2010; NICE 2004a, 2004b). Typical examples of low intensity interventions in the UK include guided self-help using written psychoeducational materials or cCBT (computerised CBT), and psychoeducation groups (Bennett-Levy et al., 2010).

Low intensity interventions were first introduced into the national health service in England as part of a stepped care system of interventions for common mental health problems. In Australia, a Federal government initiative to introduce low intensity interventions has taken a different form, with a prime focus on internet-based interventions (Titov et al., 2015). New Zealand already has some examples of locally-developed low intensity interventions (e.g. Fleming, Dixon, Frampton & Merry, 2012), but to date has not developed low intensity services on a national scale.

A particular target of low intensity interventions in England has been to increase access to disadvantaged groups, including ethnic minorities (Leibowitz, 2010). In Australia, the Federal Government initiative has specifically sought to increase e-mental health access to the Aboriginal and Torres Strait Islander first nation Australians (Department of Health and Ageing, 2012). Approximately 6% of New Zealanders experience psychological distress at any given time with higher rates for Maori (10%) and Pacific (9%) adults (Mental Health Foundation, 2014). Accordingly the relevance of low intensity interventions to increasing access to psychological therapies amongst the New Zealand population, including Maori and Pacific peoples, is quite apparent.

In England, Psychological Wellbeing Practitioners (PWP) (previously known as low intensity practitioners) have been trained to support guided self-help interventions and provide brief CBT interventions within a stepped care system (e.g. NICE, 2004a). The training for PWP is relatively brief at 45 days (20 of which are university-directed study

days) and it emphasises the acquisition of the specific skill set required to assess clients and deliver low intensity CBT-based interventions (Richards, Farrand & Chellingsworth, 2011). The majority of individuals training as PWP do not have any previous experience of delivering psychological interventions or possess a core clinical qualification, but most will have worked in the field of mental health or in a related social care role (Farrand, Rayson & Lovis, 2016).

Although the manualised nature of low intensity interventions might lead to the assumption that the technical content of the interventions is the only factor of importance, Chaddock (2013) has suggested that practitioners' interpersonal skills are central to their effective implementation:

It is precisely because you will have limited contact with the client that interpersonal factors are so important. As a LICBT [*low intensity practitioner*] you have less time to elicit the information needed to understand the client's difficulty, to develop rapport and facilitate their initial engagement with the intervention materials, and to overcome any difficulties that arise. (Chaddock, 2013, p.70)

Although this argument has face validity, until recently there has been a lack of evidence on the role of the therapeutic relationship in general, or therapeutic empathy in particular, in low intensity working. However, a recent study has identified that 9% of variance in outcomes for clients receiving low intensity interventions was due to therapist effects, with a group of PWP identified that had far higher recovery rates, and also far lower rates

of deterioration (Green, Barkham, Kellett & Saxon, 2014). Although the authors noted a range of factors that appeared to contribute to the success of these 'super coaches', general communication and interpersonal skills were identified as key, both by the PWPs but also by their supervisors. In addition, a further factor identified was the ability of the PWPs to "adapt interventions to fit individual patient needs, whilst not drifting away from treatment protocols" (Green et al., 2014, p.50).

Clearly further research is required to understand the microskills that highly successful PWPs possess, but it is likely to be consistent with research in other groups of therapists where relational skills (Jennings & Skovholt, 1999) and the ability to build therapeutic alliances (Luborsky, McLellan, Woody, O'Brien & Auerbach, 1985) have been found to be related to effective practice. Green et al. (2014, p51) concluded that "what self-help intervention patients receive is important, but also the skill with which it is delivered is vital in creating outcomes (i.e. the intervention is not a purely technical concern)", a finding that contradicts any assumption that the technical content of the low intensity interventions is the only relevant variable.

Given the above, there is a clear challenge for PWP training courses which take entrants likely to have vastly differing levels of mental health experience, psychological therapy experience, and interpersonal knowledge and skills (Farrand et al. 2016). How can a course ensure that all PWPs have the knowledge and therapeutic empathy skills needed to build trusting, warm and effective therapeutic relationships by the end of 45 days? Where do PWPs learn the empathic skills required to engage the harder-to-engage or sceptical client, never mind address the inevitable therapeutic ruptures that will occur whether due to client beliefs ("*I can't trust strangers*"), therapist beliefs ("*I am completely responsible for whether this client recovers*") or some interaction between the two? Where does the PWP learn to step back from therapeutic ruptures and examine their own thoughts and feelings before they are hooked into acting upon them? How does the PWP learn to attune to the subtle indications of what might be going on for individual clients, and

take empathic action to address this and reduce the chances of disengagement? It is likely that some of the most effective PWPs may already have high levels of interpersonal skills when they embark on their training. Alternatively, perhaps there are those who respond well to their core PWP training and then further develop their interpersonal skills through supervision and reflection upon clinical experience (Haarhoff & Thwaites, 2016). We currently do not have the evidence to confirm either possibility. Clearly the priority has to be to find a way (or more likely a range of ways) to help all PWPs develop these skills in order to improve the client experience and clinical outcomes.

Although there are specific differences between low intensity CBT and high intensity CBT, this might be an area where (in the absence of LI CBT-specific models and evidence) we can extrapolate from high intensity CBT and other psychological therapies. Empathy has previously been identified as one of the key factors in psychotherapeutic change (Bohart & Greenberg, 1997) and studies have suggested that between 7 and 10% of the variance in therapy outcomes are accounted for by empathy (Bohart, Elliott, Greenberg & Watson, 2002). Amongst CBT therapists, empathy is acknowledged to play a key role in therapy outcomes (Beck, Rush, Shaw and Emery, 1979; Burns & Nolen-Hoeksema, 1992), and a CBT model of empathy has been developed that delineates four key elements of therapeutic empathy (Thwaites & Bennett-Levy, 2007):

- Empathic attitude or stance towards specific client or clients in general
  - Empathic attunement (therapist awareness of the moment-to-moment experience of the client)
  - Empathic communication skills (direct communications to the client)
  - Empathy knowledge (factual declarative information about therapeutic empathy)

The delineation of these four elements makes it easier to identify aspects of empathy that may or may not be present in practitioners, and thus lead to an increased ability to identify training needs and targeted methods most likely to achieve the desired outcomes

(Bennett-Levy & Thwaites, 2007). For example, if a practitioner does not possess relevant declarative knowledge about empathy (e.g. knowledge of the role of empathy in engaging clients in behavioural experiments) then reading a book or paper may be one way to address this (Bennett-Levy, McManus, Westling & Fennell, 2009), but the same method is unlikely to be appropriate in order to learn procedural skills whether involving attunement to the client or the ability to communicate empathically (Bennett-Levy et al., 2009).

PWP training courses currently utilise a range of learning methods to help enhance practical skills including demonstration, role plays and assessed visual recordings. One specific solution developed for PWP training to maintain or enhance therapeutic empathy has been to use 'empathy dots' in assessment schedules to remind trainee PWPs to use empathy skills, and not neglect them whilst they are developing new PWP-specific skills. Richards and Lovell (2010) have described empathy dots as:

... marks which a high-volume mental health worker puts into the margin of a pre-printed or hand written psychotherapy interview schedule that is about to be followed during an appointment - seeing the dots reminds the worker to say something warmly empathic and/or understanding at intervals within the interview. (Richards and Lovell, 2010)

Although a reminder not to forget basic interpersonal processes whilst implementing new technical skills is likely to be a very useful prompt, trainers have started to think about additional ways to develop and embed the interpersonal skills of both trainee PWPs (Farrand et al., 2016) and experienced PWPs (Thwaites et al. 2015). One of those ways is a method of training CBT therapists called Self-Practice/Self-Reflection (SP/SR) that has already been trialled in New Zealand (Fraser & Wilson, 2011; Haarhoff, Gibson & Flett, 2010; Spafford & Haarhoff, 2016). SP/SR places particular emphasis on understanding CBT 'from the inside out' - by participants experiencing CBT interventions for themselves and then reflecting on this and applying their learning within their clinical practice

(Thwaites et al., 2014).

There is a growing evidence base for the effectiveness of SP/SR in improving skills in trainee CBT therapists (Chaddock, Thwaites, Bennett-Levy & Freeston, 2014), newly qualified CBT therapists (Haarhoff, Gibson & Flett, 2011), experienced CBT therapists (Davis, et al., 2015), trainee clinical psychologists (Bennett-Levy et al., 2001) and practising clinical psychologists (Bennett-Levy, Lee, Travers, Pohlman & Hamernik, 2003). There is also a suggestion that self-practice might be perceived as an effective training strategy for Indigenous Australian counsellors (Bennett-Levy, et al., 2015a), which may have relevance for the training of Maori counsellors. Of particular note is the fact that the primary impact of SP/SR is on the interpersonal aspects of therapy (Thwaites et al., 2014). By having an experience of being in the client's shoes, therapists report that they have a greater attunement to clients, and greater understanding of the client experience and potential difficulties within therapy (Bennett-Levy et al., 2015b). A recent meta-synthesis of SP/SR research to date concluded that "self-practice/self-reflection can be particularly helpful for increasing empathy for clients, highlighting the difficulties they may encounter" (Gale & Schroder, 2014, p.373).

SP/SR aims to move from personal experiences to new professional learning via a structured process of reflection (Bennett-Levy et al., 2015b). For PWPs (and therapists in general), SP/SR is likely to provide a new and different experience of learning. The aim is to move from observation to reflection, bridging between personal experience and professional knowledge and skills.

### ***Aim of the study***

A previous paper had detailed the impact of SP/SR on the CBT-specific skills of experienced PWPs and the artistry with which they implement interventions (Thwaites et al., 2015). Within the PWP reflections, it was also noted that there were frequent mentions of SP/SR impacts on empathy, which suggested that a retrospective analysis could provide initial data around the differential impacts of SP/SR on therapeutic empathy. For the current

paper, these data have been re-analysed to describe the impact of SP/SR on the therapeutic empathy in the same group of PWPs.

As indicated above, Thwaites & Bennett-Levy (2007) and Bennett-Levy & Thwaites (2007) have previously suggested that therapeutic empathy can be conceived as comprising of four elements: declarative knowledge about empathy, empathic attitude/stance, empathic attunement, and empathic communication. Accordingly, the aim of the present study was to carry out a retrospective analysis to review all practitioners' reflections about empathy to see if SP/SR might have a differential impact on different elements of empathy.

## **METHOD**

### ***Participants***

Thirty nine (36 female, 3 male) qualified PWPs within a large English psychological therapy service received one day's training on the role of reflection in low intensity psychological therapy. In line with identified best practice for SP/SR (Bennett-Levy, et al., 2015b), they were then given relevant information on SP/SR (e.g. time commitments, confidentiality) and invited to attend a meeting to find out more if they were interested in participating in the SP/SR programme.

Participation in SP/SR was voluntary and following this process a group of seven PWPs (all female) chose to take part in the programme. The practitioners who chose not to take part cited time or ongoing life events as the main reason for not taking part (Haarhoff, et al., 2015). Two participants failed to complete the programme due to life events. The seven participants had a mean post-PWP qualification experience of 2.57 years.

### ***Procedure***

The study followed the procedural recommendations for best practice in SP/SR implementation (Bennett-Levy et al., 2015b) including a pre-programme meeting at which the group made key decisions around the programme implementation, two face-to-face group meetings of 90 minutes each (at Module 4 and Module 9) and the development of personalised Personal Safeguard

Strategies (to be used in the event that SP/SR raised unexpected distress which required support – see Bennett-Levy et al., 2015b).

All participants were trained to access an online message board. The participants discussed boundaries and confidentiality, and unanimously voted to use their real names rather than anonymous names. Participants chose to complete each module over two weeks rather than one to allow sufficient time to practice (one module was stretched to three weeks). They were encouraged to read the module and implement the SP during the first week of the module. Initial postings to a message board were to be made by the end of the first week. The second week of each module was dedicated to posting enquiries and comments on other reflections and sharing learning and application to clinical practice.

### ***Materials: SP/SR Workbook***

The workbook content is described in detail elsewhere (Thwaites et al., 2015) and has now been published (Bennett-Levy et al., 2015b). Some of the SP activities mapped directly onto interventions that PWPs would utilise in their day-to-day clinical work with clients (e.g. developing problem statements, behavioural activation) whereas some were not within the LI remit and were clearly identified as personal development activities (e.g. using imagery to identify and strengthen 'New Ways of Being').

### ***Measures***

Participants were not specifically asked to include impacts on therapeutic empathy within their reflections. However previous studies (Bennett-Levy et al., 2015b) and our previous experience of delivering SP/SR suggested that reports of enhanced empathy were common. One year after completion of the programme, a researcher group of three participants and two facilitators re-analysed all of the reflections recorded in the online message board in order to identify text which clearly represented each of the four elements of the Therapeutic Empathy model for CBT (Thwaites & Bennett-Levy, 2007).

All examples of empathy were noted and categorised by the researchers

into one or more of the four elements. Where there was agreement between the researchers about the categorisation, the data were listed under their respective element. In cases where the researcher group disagreed about the categorisation, these examples were discussed; agreement about categorisation was either reached between the researchers, or the item was discarded from the analysis as ambiguous.

Examples of the four elements are:

**Empathic stance/attitude:**

Examples of a change in empathic attitude or stance are participant reflections that demonstrated a shift in attitude towards clients in general, or towards specific subgroups of client (e.g. “*I struggle not to feel annoyed with the type of client who repeatedly turns up at sessions and hasn’t done their homework or made any changes*”).

**Empathic attunement:** Examples of empathic attunement would include reflections where practitioners have noted that they have made “*an active ongoing effort to stay attuned on a moment-to-moment basis with the client’s communications and unfolding process*” (Bohart et al. (2002, p. 90).

**Empathic communications:**

Examples of empathic communications would include reflections which demonstrate that there has been a change in the way that empathy has been directly communicated to the client: for example verbally in terms of content, or non-verbally through facial expression, tone of voice or behaviour (Thwaites & Bennett-Levy, 2007).

**Empathy knowledge:**

Empathy knowledge is declarative knowledge about therapeutic empathy. Typically empathic knowledge is most commonly is learned through reading literature or didactic information in workshops (e.g. knowledge about the importance of empathy to client outcomes). Examples of changes in empathy knowledge might be reflections that indicate new understandings about the role of empathy in helping clients to change.

Participants also rated themselves weekly on a number of standard items taken from the Cognitive Therapist Empathy Scale (Thwaites, Bennett-Levy, Freeston, Armstrong & Cromarty, 2003). They were also encouraged to choose

a small number of individual items from the scale that were in line with their development needs. Examples of these ratings are reported in the Results section.

**RESULTS**

**Overall finding**

Self-reported changes in the interpersonal domain, and in particular empathy, were noted in each of the modules. Based on the number and quality of reflections within each category, there appeared to be a differential impact of SP/SR, with greater impact on some domains of empathy than others. The primary impact of SP/SR appeared to be on empathic stance/attitude.

Results for each of the four elements of therapeutic empathy are reported below. Participant self-ratings are also used to illustrate changes that appeared to be brought about by SP/SR.

**Empathic stance/attitude**

There were many examples of shifts in empathic stance/attitude throughout the modules. For instance, one participant noted that ‘*I guess this helped me to appreciate that people can find it hard to set specific and suitable time aside to do homework tasks.*’ This quote shows how the completion of the module allowed the PWP to recognise that some clients may face a specific difficulty finding time during the therapeutic process. Another participant noted that ‘*[this] definitely made me empathise with those clients who struggle with thought recording – I was reluctant*

*to write mine too!!*’ What is lacking in both these examples is evidence of translation from change in stance/attitude to change in therapist behaviour (enhanced attunement or communication skills).

There were many more examples of a shift in empathic attitude or stance, but with limited comment on how that might inform work with future clients, for example ‘*This definitely made me think about what some clients must feel when I casually ask them to tell me how much they believe a thought, or how strongly they experienced an emotion.*’

Some examples showed a stronger level of empathy and compassion emerging for clients:

*‘I struggled with starting this task which has given me insight into clients. I set a time to sit and do modules after a false start. When I did start it I already felt “behind”. I thought of clients who say “I haven’t done it” and found new level of empathy and also appreciation for admitting that’*

and

*‘Reflecting back on the modules the biggest change for me is how I view the work I do with my most difficult clients, I have certainly become more compassionate towards them and have noticed a measured change in attitude – I know this is because I now understand how difficult the process is for a relatively well person (me) without stressful life circumstances, and without depression or anxiety!’*

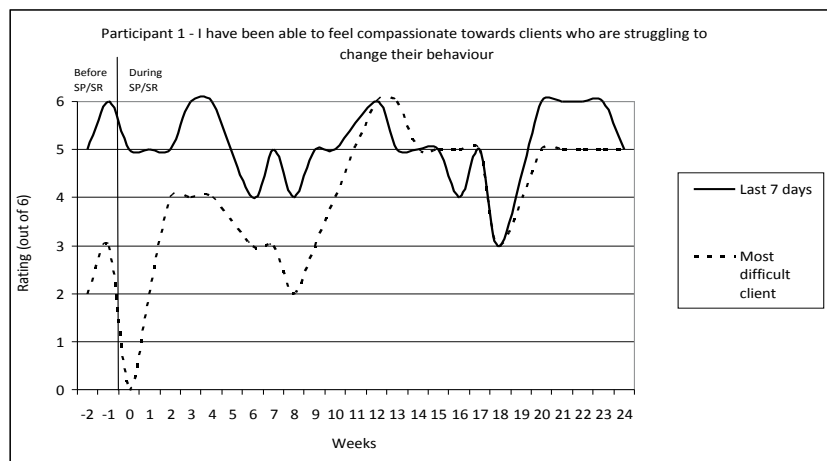


Figure 1. Graph illustrating differential response for “average client” versus “most difficult client”

As in previous studies (Davis et al., 2015; Thwaites et al., 2015) the self-rated impact of the SP/SR was usually greater for the “most difficult client seen in the last seven days” than for the “the average client seen in the last seven days”. An example of this is illustrated in Figure 1 where the PWP experienced limited change in her ability to feel compassionate towards their average client in the week but illustrates a far greater change for the most difficult client during the week.

**Empathic attunement**

We were unable to find any specific descriptions of changes in moment-to-moment attunement in practitioner reflections, even though they were hinted at. The examples below demonstrate an intention to change implied in the reflection, but do not provide a clear example of empathic attunement in practice:

*“So when I started this module last week I thought it would be good to complete before my hectic weekend of socialising and making plans for moving house. However, what I found is that condensing the task made it more confusing. This has given me insight into the world of the client. I think I will be more encouraging for people to take their time with things, or at least put more thought into homework planning”.*

Another reflection appears to show increased awareness of a client’s resistance, and suggests the potential for greater empathic attunement: *“Also with a client with depression and perfectionist thinking it offered insight, we have discussed using behavioural activation again. I am now more aware of resistance to the intervention based on anxious thoughts where previously I may have overlooked these”.*

From the data, it is unclear whether the absence of specific examples of empathic attunement means that there were no such examples, or that there were changes which practitioners did not report.

**Empathy communication skills**

There were some clear examples in the modules of how PWPs were

communicating about low intensity interventions differently with their clients. One PWP described:

*“I feel I have become much more confident in explaining the rationale for getting a problem statement, setting goals and reviewing progress and as such I have noticed an improvement in clients completing homework tasks, coming ready to sessions to ask questions or problem solve an area of self-help they feel they have got stuck with. Overall being able to say to clients that there really is no right or wrong way to do the things I am asking them to do and explain that it is more about the process and truly believe this as it comes from my own experience I think has made the biggest difference.”*

and

*‘I have to say that I have gained such a lot of insight into what it might feel like from the client perspective when they pitch up for help and that this experiential process has helped me to change lots of small things about the way I interact with clients, how I explain things, and the compassion I feel for those clients who take a long time to get us (often those with multiple failure to engages and treatment episodes) DNA, don’t complete homework or disengage.’*

PWP self-ratings on the Cognitive Therapy Empathy Scale typically demonstrated small increases in empathic communication skills e.g. the ability to convey to clients that the way they were feeling was understandable (empathic communication). Figure 2 provides an example.

**Empathy knowledge**

We were unable to find any examples of the participants describing an impact on declarative knowledge regarding empathy in the participants’ reflections. There were clear examples of new learning but these tended to be more descriptions of changes in empathic stance and attitude having experienced therapy from the inside out, rather than descriptions of developing new knowledge (e.g. about the role of empathy in therapy).

**Discussion**

Consistent with previous studies of SP/SR with a range of different therapists (Gale & Schroder, 2014; Thwaites et al., 2014), the present study suggests that SP/SR may be an effective post-qualification development strategy for enhancing PWP interpersonal skills and in particular empathy skills. The analysis of practitioners’ reflections suggested a differential impact of SP/SR on different elements of therapeutic empathy, with the greatest impact on therapist stance/attitude and little or no impact on therapist declarative knowledge. There appeared to be a moderate impact on empathy communication skills, but relatively little reported impact on empathic attunement. Therefore, while there was clear evidence of a change in attitude towards the client’s experience from PWPs’ own self-practice, there was only limited evidence of the transfer of this new understanding to the clinical skill of empathic communication, and no direct evidence of transfer to empathic attunement.

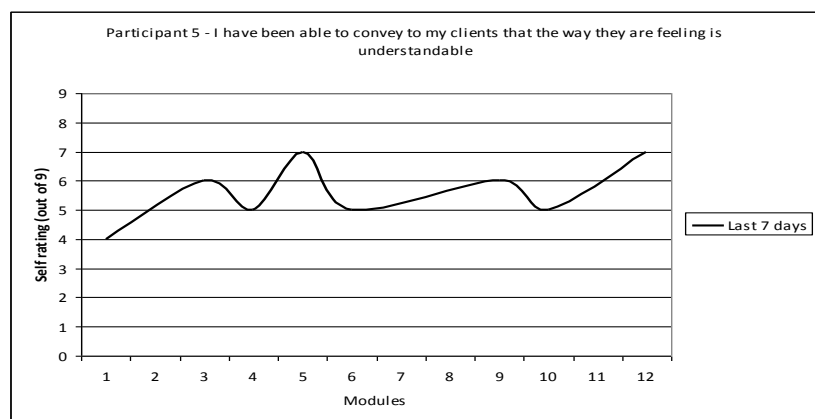


Figure 2. Graph illustrating example of self-rated aspect of empathic skill

There are several possible explanations for a differential impact of SP/SR on different therapy skills. One explanation might be that there is a reporting bias. It may be that all elements of empathy are impacted by SP/SR, but that it is easier for practitioners to notice a change in attitude and a change in communication skills than a change in attunement or knowledge, which may be largely implicit processes without an easily observable external component. We consider this unlikely for the reasons below.

in the SP/SR workbook are designed to facilitate this (e.g. “...How will this affect your attitude or approach towards this particular client? What will you be doing differently in your sessions? What will this look and feel like?”).

In retrospect, we suggest that the translation from empathic stance/attitude to empathic attunement and communication skills might have been enhanced if the SP/SR facilitators had provided clearer guidelines on what to reflect on, and created follow-up questions on the message board for moving

understandings of empathy. The DPR model (Bennett-Levy, 2006; Bennett-Levy & Thwaites, 2007) and previous research would suggest that experiential approaches such as SP/SR typically do not tend to impact directly on declarative knowledge (Bennett-Levy et al., 2009), except in novice therapists with little or no declarative understanding (Bennett-Levy et al., 2001). Accordingly, the already high levels of declarative knowledge pre-programme in these more experienced practitioners might account for the absence of reported declarative knowledge gains.

There is one other noteworthy difference between the present study and a previous SP/SR study with experienced CBT therapists where the therapists reported changes in attunement and communication skills (Bennett-Levy et al., 2003). In the previous study, the experienced therapists undertook a different form of SP/SR – ‘limited co-therapy’ pairs, where each therapist gave and received five sessions of CBT focused on a particular issue, and then reflected on the experience. Quite apart from the differences in experience and training between the present participants and the 2003 study, we suspect that opportunity to experience attunement and interpersonal communication skills directly from their partner and to reflect on the impact on themselves highlighted the value of attunement and communication skills. Furthermore, the co-therapy form of SP/SR enabled them immediately to monitor and practice their own attunement and communication skills, and notice how SP/SR created a difference. We suggest that, where therapists already have the requisite face-to-face CBT skills, the ‘limited co-therapy’ form of SP/SR may be particularly helpful in translating empathic stance/attitude into attunement and communication skills, since it enables immediate reflection and practice of the skills with a partner.

### Limitations of the study

The study methodology relied on the researchers’ data analysis to determine which of the four elements of therapeutic empathy were present in practitioners’ self-reflections. However, no specific instructions had been given to the practitioners to reflect on their experiences of empathy, and no instruction was given

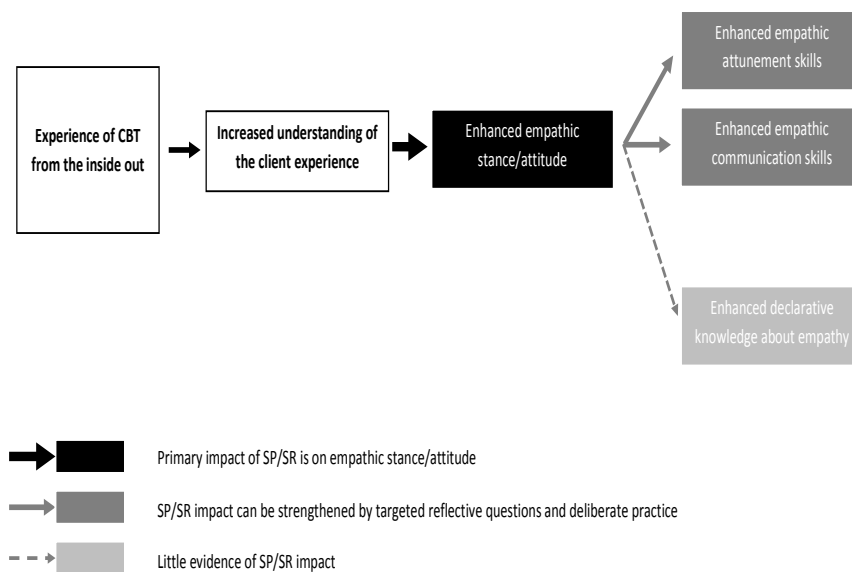


Figure 3. Hypothesized differential impacts of SP/SR on the four elements of therapeutic empathy

A second, and in our view more likely, explanation is that the most direct impact of SP/SR may be on therapist stance/attitude as a direct result of practitioners’ emotional experience of SP/SR and their own struggles to change behaviours. This idea is illustrated in Figure 3. According to this hypothesis, changes in empathic attunement and communication skills are likely to require further reflection and deliberate practice (Bennett-Levy & Thwaites, 2007; Chow et al., 2015). We have previously suggested that one of the key processes in SP/SR is the use of self-reflection to ‘bridge’ between the Personal Self (experience of CBT from the inside out) and the Therapist Self (professional learning) (Bennett-Levy & Haarhoff, in press; Bennett-Levy et al., 2015b). The structured self-reflections

from reflection into implementation in practice. This would have ensured deeper and more professionally useful reflection and maximised learning from the self-practice. For example, if a participant’s reflections were only on their personal experience, the facilitators could have provided more guidance to assist them in creating a ‘reflective bridge’ between personal self-reflection and therapist self-reflection (Bennett-Levy & Haarhoff, in press). Ideally, the bridge would not only assist practitioners to look at the implications of their personal experience for their therapeutic practice, but would lead them to translate their new understandings into new practices with clients.

It was not a surprise that no changes were reported in declarative



about these four elements and the need to distinguish between them. Therefore, we cannot know for sure whether these unguided reflections represent the degree to which there was change (or not) in the four elements. Furthermore, practitioner reflections on a discussion board may not be the best way to note changes in the four elements as typically the reflections may be written some time after clinical contact.

Another limitation is that the sample size of participants is small. The study would have benefitted from more participants who might have provided examples across each of the four elements of therapeutic empathy. This particular group of participants were all experienced and effective PWPs with no identified therapeutic empathy deficits prior to the study. The study provides some evidence of how SP/SR can help to enhance empathy skills in a relatively skilled group of practitioners but does not tell us anything about whether SP/SR would help an individual with general low levels of therapeutic empathy (Bennett-Levy & Thwaites, 2007).

The quantitative aspect of the study relied on one measure of empathy based on self-ratings, and did not include any client-rated measures or observer ratings, either of which would be desirable. It would be helpful if future studies included such measures where possible.

## Conclusions

This pilot study provides some support for the use of SP/SR as a focused training strategy for experienced PWPs to develop enhanced empathic stance and skills. There was also some evidence that the impact of SP/SR was maximised when PWPs were faced with more interpersonally challenging clients who required the practitioner to “flex” low intensity interventions while resisting therapeutic drift. Further studies are needed to examine the impact of SP/SR on therapeutic empathy and other interpersonal skills and knowledge of trainee PWPs (Farrand et al. 2016). Although empathy dots can provide PWPs with clear reminders not to forget basic therapeutic empathy whilst training, SP/SR may provide more specific empathy skills training, particularly if trainers facilitate reflective questions and practices which help

practitioners to translate changes in empathic stance/attitude into attunement and communication skills. If New Zealand is to introduce PWP training at some time in the future, SP/SR should be considered as a potentially valuable training strategy to enhance interpersonal skills and integrate them with the low intensity technical skills.

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