

1 Flying over the swampy lowlands: Reflective and reflexive Practice

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Musing, contemplating, daydreaming, wondering, doubting, guessing, intuiting, criticizing, learning: all these states of mind and many more might be evoked when we ask ourselves what we are doing in reflective moments. The term 'reflection' comes from Latin roots, *re-* meaning 'back' and *flectere* meaning 'to bend', and was first applied in the context of light itself 'bending back' off reflective surfaces. Perhaps it comes as no surprise then that the physical metaphor of a 'mirror', quite literally reflecting our own image back to us, so readily springs to mind. Indeed, the whole notion of reflective practice often draws criticism from the uninitiated, who naively believe that little more is involved than narcissistic navel gazing, an unnecessary luxury in target-driven times. The handsome, yet hapless, Narcissus met his fate through doing nothing other than admiring his own reflection in water (see Figure 1.1) and, somewhat paradoxically, ultimately perished through self-neglect. In this book we hope to demonstrate that reflective practice and reflexive thinking are essential components of therapy and counselling.

Far from trapping us in self-adulation, reflective and reflexive processes potentially allow us to be self-critical and ethical in our clinical practice, nurturing our development as therapists and sustaining our practice-based learning. In this chapter we set out to explore the origins and basic meanings of reflective practice to lay the ground for understanding it in the context of psychotherapy and counselling. It seems that the term 'reflection' was first applied to thought processes in the early seventeenth century, meaning literally to 'turn one's thoughts (back)'. Once we translate reflection into the broader domain of human intellectual processes, the possibilities for using different representational systems – sensory imagery, emotions, cognitions, stored actions, memories and language – open up advanced opportunities for engaging in forms of reflective activities that are unique to human beings as



Figure 1.1 Echo and Narcissus © National Museums Liverpool

a species. We shall consider the biological and evolutionary roots of reflective functioning in more detail in Chapter 2. In this chapter we aim to identify some of the key processes that define the act of being reflective.

The term 'reflective practice' has gained considerable significance in contemporary clinical practice. Though we might think that it is fundamentally related to the practice of psychotherapy and counselling, in fact there has been substantial interest across a number of professional practices including nursing (Taylor 2006), social work (Gould and Taylor 1996; Fook 1999), general health practitioners (Kember 2001), medicine (Greenhalgh and Hurwitz 1998), education (Boud et al. 1985; Jarvis 1995) and in areas of management and leadership (Schön 1983). Reflective practice, it seems, has fast become an essential component of training and best practice for many professionals who work directly with people. However, previous accounts of reflective practice have tended to emphasize its roots in educational theory and philosophy (Dewey 1938). Within this book we certainly recognize the central importance of reflective practice as an essential component of learning within the main models of psychotherapy practice and counselling, and more generally within applied psychology and clinical psychology. However, we shall also argue that, for these purposes, a thorough exploration

of reflective practice needs to be balanced with a psychological analysis of what it means to be reflective from a uniquely human perspective.

Our framework for understanding reflective practice is broadly based on a bio-psychosocial approach (Engel 1977; Gilbert 2001) to mental health and well-being; we need to account for reflective processes at multiple levels of analysis, from the biological and intraindividual through to interpersonal, relational, social and cultural levels. In this chapter and the next we explore the range of phenomena included within the scope of reflective practice and seek to understand the biological origins of reflective functioning as a human intellectual activity. Across the different chapters, greater emphasis may be placed upon these different levels of analysis to offer descriptions and explanations of psychological problems. For example, psychodynamic therapy traditionally focuses on intrapsychic processes, while systemic therapists work much more with relationships between people; narrative therapists seek to understand difficulties within the wider social and cultural context, and so forth. In our view, working with people from any one of these many therapeutic perspectives poses a uniquely challenging problem, because the theories that we have about our clients are essentially the same as the theories that we hold about ourselves and our practice. We cannot 'stand outside' the act of therapy in quite the same way that we can observe ourselves, say, learning to ride a bicycle or practising a piece of music. The reasons for this lie partly in the dialogical, relational aspects of 'doing' therapy – the therapist becomes a part of the very process that she is trying to step back from and observe. We shall try to make sense of how reflective practice can be theorized to take account of this 'insider' perspective that a counsellor or therapist inevitably inhabits.

Each chapter offers a different theoretical account of how reflective practice might be used during the practice of therapy from the perspective of a particular psychological model. Our aim in this book, then, is to draw together these different perspectives and to offer, in the concluding chapter, an overview and integration of what psychological theory has to offer by way of a fresh understanding of this field. We hope that, by drawing out comparisons and contrasts between the different models, we may gain some further clarification and advancement in our understanding of reflective practice as a psychological process. In particular, as both trainers and clinicians ourselves, we aim to provide a useful resource for training and practice.

Reflection and reflexivity

In turn, we need to be reflective about reflective practice and to consider, for example, that it may not invariably or entirely be a good, wholesome, positive activity. The meanings of reflective practice similarly need to be

subject to a reflective and critical scrutiny. It is argued that reflective practice involves complex processes that allow us to see things in new ways, viewed through the lenses of our different models for understanding therapy. However, questions arise about how we do this reflecting, why we do it, who it is for and, importantly, who looks at, inspects or even assesses our reflective practice. These specific contexts of therapy can cause distortions and illusions even in our very attempt to rise above specific things in our reflective practice. Critically, as reflective practice increasingly becomes a requirement of many training programmes and of professional practice, it can also be seen to contain elements of surveillance, inquisition and a form of required 'confessional' about our practice (Bleakley 2000; Taylor 2006). Perhaps even more problematic, is when reflective practice becomes designated as a required measurable 'competence' and trainees and practitioners need to demonstrate skill and adherence to principles of reflective practice. Assessment of such competence frequently requires written accounts, and these can be seen to be constructed so as to persuade trainers and supervisors that the therapist can pass as a competent practitioner. It is thereby not simply, or even predominantly a neutral, unbiased process but also needs to be analysed and critiqued as an activity in its own right.

We suggest that reflective practice is best seen as a successive process of analysing and reanalysing important episodes of activity, drawing on multiple levels of representation. This includes propositional, autobiographical and ethical knowledge yet does not squeeze out the serendipitous and playful potential for learning from our very personal experiences. We shall limit the term *personal reflection* to refer to the spontaneous and immediate act of reflecting in the moment. We suggest that use of this term is restricted to describe reflection *in* action, most usually during therapy, but this could also be applied to other professional contexts such as supervision, consultation, teaching and learning. In contrast, we use *personal reflexivity* to refer to the act of looking back over, or reflecting *on*, action. This implies a metatheorized processing of events retrospectively, where the original episode of reflection becomes the object of further conscious scrutiny.

Hence, in our view, personal reflection typically encompasses self-awareness of bodily sensations and emotions and the attentional focus on memories, experiences and cognitions as evoked during *in-the-moment* reflective episodes. This definition is deliberately broad so as to encompass the diverse content of personal reflections that might be encouraged across the range of different therapeutic practices. We shall re-examine this idea again in the concluding chapter.

In contrast, we consider 'personal reflexivity' to be primarily a conscious cognitive process whereby knowledge and theory are applied to make sense of remembered reflective episodes. This draws on multiple sources of prior knowledge, including model-specific theories of psychological proc-

esses, a theorized understanding of one's own social status and situation in terms of gender, class and ethnicity, and self-narratives that represent autobiographical accounts that story our own life experiences. We draw here on Chinn's usage of the term 'personal reflexivity' to refer to 'the way that the [therapist] acknowledges how her own agendas, experiences, motivations and political stance contribute to what goes on in work with clients' (Chinn 2007: 13). However, we are including the therapist's subjective perceptions of interpersonal power and inequality as important aspects both of personal reflective and reflexive processes, since awareness of one's own relational position could easily be triggered in the moment of therapeutic engagement as well as providing an important point of reference for looking back over the therapy.

We also believe that reflexivity can be a creative, artistic and playful activity that utilizes a person's selfhood and agency beyond the narrower confines of their acquired academic knowledge, in this case their declarative and procedural knowledge of how to do therapy. We want to extend our concept of personal reflexivity beyond the application of acquired propositional knowledge regarding one's theoretical and political agendas to include the experiencing of our own embedded set of aesthetic preferences and values that are a matter of personal choice (Bleakley 2000). Many authors in this book have generously revealed aspects of their own preferences, their likes and dislikes of particular ways of working or being with their clients, and we need, above all, to make room for the uniquely personal nature of reflexivity that can lead to fresh insight and learning 'outside the box'.

In offering these definitions, we acknowledge that there remains confusion, overlap and inconsistency within the literature regarding the exact terminology for labelling different aspects of reflective practice. Although our definitions here have incorporated Schön's distinction between reflection in, and reflection on, action to include a 'levels-of-processing' account of multi-layered reflective practice drawing on both propositional and experiential sources of knowledge, they are by no means straightforward.

To start with, our definition implies a two-stage process whereby first-order episodes of reflection in action later become the object of second-order processing. We recognize that these two levels interact and are not always clearly delineated in temporal sequences. In the first place, the content of reflection will be influenced by 'top-down' processes as well as 'bottom-up' processes; what we notice when we are practising therapy is influenced by what we privilege according to the espoused theory that guides our practice. In information-processing terms, this is known as 'heterarchical' processing. For example, a humanistic therapist might pay more attention to the hunched posture of a client, while the psychodynamic therapist might be highly attuned to hesitations and omissions in what is spoken as indications of defensive processes at work. Systemic therapists might notice where family

members sit, reading into this patterns of family closeness, while a narrative therapist may be listening out for missing stories, clues to the preferred narratives that have more hopeful trajectories. Although this is parodying the different models somewhat, it makes the point that our perceptions are selectively filtered according to our knowledge frameworks – so that the greater our experience, the more we are predisposed to notice what we ‘know’, or presume, to be important.

Another difficulty in distinguishing between ‘reflection’ as an immediate activity and ‘reflexion’ as a later stage of processing is that, in practice, the temporal sequencing of events is not quite so discrete. The distinction between reflection in and on action is more blurred in some models of practice than in others. For example, sometimes supervision is clearly offered to provide space for thinking outside of past therapy sessions. In the practice of psychodynamic psychotherapy, the supervisee often takes material from a session with a client, including dialogue, drawings and personal reflections, and explores the meaning of these with the supervisor, expanding and interpreting their understanding of their work. Here the distinction between reflection in the therapy itself and retrospective meaning-making are relatively clear-cut. However, many systemic therapists monitor their own reflections with a view to sharing them fairly directly with a family. Reflections may be further elaborated in front of the family in conversation with a live team of co-therapists. In this way reflecting upon reflecting becomes part of the ongoing therapeutic process, and both occur in the moment of the therapy (see Chapter 8). So we see that the temporal relationship between reflection in action and retrospective supervision can also become blurred. Of course we are also capable of experiencing in-the-moment reflections even while actively engaged in higher levels of processing, perhaps noticing aspects of our relationship with our supervisor during the act of receiving supervision, and so on.

In spite of these practical difficulties, we think it is useful to conceive of personal reflection and reflexion as a dual process. If we practised only the former without the latter, reflective practice would be potentially self-serving and empty, privileging self-awareness for its own sake over and above its use in facilitating therapeutic change. On the other hand, theorizing therapy only from a distance, without attention to the moment-by-moment detail, would be inauthentic and meaningless.

Reflection is often developed in the context of supervision, where conversations about the meaning of experiences and how they fit with the theoretical assumptions of our models are encouraged. Very often, then, our looking back on moments in therapy, our accounts of our subjective states and feelings, become reconstructed as narrative dialogue between therapist and supervisor. It is within these exploratory discourses that we begin to shape our identities as professional therapists. We learn from our successes

and mistakes, we identify our beliefs and values and gain a sense of what we 'should' be doing. Learning 'how' to reflect, what are the legitimate forms and contents of reflective discourses, forms part of our professional development and we shall return to this idea once we have established the repertoires for reflecting that characterize the different models.

Examples and activity

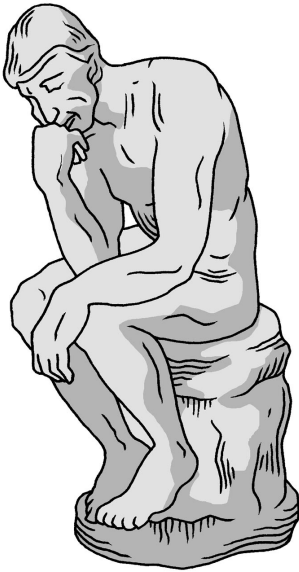


Figure 1.2 The Thinker

We might start by examining the role of reflective practice in our own professional development from training to our contemporary practice. To what extent and in what ways were you encouraged, invited or motivated during your training to consider reflective practice? Did your training include a discussion of what this may have meant? How was it conceptualized? For example, did you experience an encouragement to reflect on your ongoing feelings during clinical practice or therapy, or perhaps your personal development, childhood and family experiences, and how did this enter into your work? Did it include an invitation to think more broadly about sociocultural issues, such as class, gender and ethnicity, and how our own relative positions influence work with clients from diverse backgrounds? Alternatively, you may have used supervision to look back over clinical experiences where something went 'wrong' to figure out how to avoid making this 'mistake' again in future. Or perhaps something went unexpect-

edly well and you were prompted to learn from your success. In either case, a particular 'aha' moment may have triggered critical reflection about the process of 'doing' therapy. To help you focus more on this, perhaps you would like to participate in the following exercise:

Think of an experience, either in your clinical practice or during your clinical training, where you were prompted by an episode to a period of significant reflection. This might be either a positive episode where something went surprisingly well or where a difficulty arose. How did you attempt to deconstruct the situation?

RD: I was invited to write a paper for a special edition of the journal *Clinical Child Psychology and Psychiatry* which was originally to be called 'Learning from our Mistakes'. My internal dialogues featured many ambivalent thoughts as I struggled to think about this activity. The preliminary examples that sprung to mind dwelled on some moments of failure, ignominy, embarrassment and shame and were accompanied by thoughts about how to justify my actions. In fact, even now as I write, I am finding it very hard to disentangle my emotional responses from more rational thoughts. One recurring observation is that there must have been some form of error in my thinking, that I had 'got something wrong'; within the therapeutic episode there was a sense of fracture, a misunderstanding between myself and my client. Sometimes these internal responses predominantly have an emotional focus, for example, that I should have been more assertive, even more overtly authoritative, in some cases. At other times, there is more of a theoretical conceptualization about what had occurred, presenting me with some alternative ways of making sense of the situation. As I engage in thinking again, with the wisdom of hindsight about these experiences, I am mindful that there are many occasions in therapy where we have to take some risk; we cannot totally predict what will happen next, nor reliably anticipate the outcome. So this nagging sense of getting things wrong, of not being a 'good enough' therapist, may be part of an illusory belief as we search for greater certainty about our work.

In the end, the example I chose to write about was of working with a young man (Steve), aged 17, who was 'diagnosed' with an obsessive-compulsive disorder. This medical label came more from his mother than any of the professionals who had worked with him. Working as a family therapist, I came to the formulation that Steve, rather than suffering with a specific diagnosis, was caught up in a set of continuing conflicts between the adults in his life, namely between his separated parents and also between his mother and stepfather. However, as I increasingly 'took his side', viewing him as a victim of oppression within his family, I lost my position of neutrality and ignored his mother's increasing demands for him to receive cognitive behavioural therapy (CBT) for his OCD. Looking back, I wondered

whether I had become ensnared by my own hubris to prove his mother wrong, rather than acting out of a genuine regard for Steve's best interests. Had I been more accepting of his mother's wishes, home life for Steve might have been easier. I had participated in team supervision about the case, and was offered a reflection given from a more psychodynamically orientated way of working: maybe Steve's mother was triggering aspects of my own struggle with my own mother (counter-transference) and I was projecting my hidden desire to prove my mother wrong. At first I was reluctant to accept this interpretation because Steve's mother didn't seem to be very much like my own. Upon further reflection however, a helpful connection formed in my mind. I realized that I also used to fight with my own mother about how to manage my half-brothers. I felt caught in a bind where she would ask me to take responsibility for them, but would not allow me to 'do it my way'. This power struggle resembled the situation occurring with Steve; his mother wanted me to offer a treatment that I did not feel was appropriate. An important point here is that my insight, though seemingly quite elementary, arose out of reflection that occurred in the wake of powerful emotional currents. If not well contained through supervision, our reflective processes can become suffused with anxiety and self-doubt so that we oscillate unhelpfully between competing ways of seeing things. Helpful supervision can provide us with insights that allow us to extricate ourselves from powerful processes in clinical work.

Finally, reflection is not simply an internal process, but can be one of telling our story to others through conversations with colleagues, and even engaging in the process of reflective writing. In this case, my perceptions have changed as I have written about these experiences and my understandings have changed as I talk about such incidents to colleagues and friends.

Earlier we pointed to the way that such reflective accounts as RD's above can also function as a form of 'confessional' whereby we are able, even encouraged, to admit our mistakes and failings so as to distance our self from them and suggest that we have moved beyond such errors. Furthermore, as RD wrote such a reflective 'on' action account, it was not simply 'straight from the heart' but shaped by his thoughts about how he is presenting himself here. The final text was influenced by questions such as: How do I come across? How much of my more negative feelings and thoughts is it OK to reveal? Is it appropriately ethical and aware of issues of diversity and equality? Writing for a professional readership, we are also prompted to reflect whether the account is too naive and reveals too much inexperience.

The 'messiness' of clinical practice

Donald Schön (1983) drew our attention to the similarities between practitioners who are engaged in skilled professions as diverse as medicine,

architecture and business. He was interested in how experts in their chosen fields (medicine, law, architecture, therapy) conduct their moment-by-moment decision-making about what to do next. Schön found that, far from being governed by explicit rules and informed by a propositional knowledge base, these experts drew instead on implicit and intuitive knowledge that could not readily be translated into formal practice guidelines. They appeared to rely on implicit procedures acquired through experience 'on the job' to guide their actions, rather than on a shared body of professional wisdom. They had a personal sense of 'know-how' that did not clearly translate into formal knowledge. Thus Schön showed us the significant gap between espoused theories, based on objectively derived and externally validated scientific methods, and the tacit theories that, in reality, appeared to guide day-to-day 'professional' practice. This prompted Schön to consider how the problems encountered in everyday situations might fundamentally differ from the kind of 'problems' that seem more open to scientific scrutiny.

In the varied topography of professional practice there is a high ground where practitioners can make effective use of research based theory and technique, and there is a swampy lowland where situations are confusing 'messes' incapable of technical solution. The difficulty is that the problems of the high ground, however great their technical interest, are often relatively unimportant to clients or to the larger society, while in the swamp are the problems of greatest interest.

(Schön 1983: 42)

Arguably, we can see much of the practice of therapy and clinical problems as located firmly in the swampy lowlands!

Central to his argument is the need to question what is so easily taken for granted, namely that we know what the 'problem' is. In clinical work this is often far from clear. Typically we begin with a referral from another professional or a self-referral from a client, wanting something to be done about a difficulty. But what exactly is the problem? For whom is it a problem? How has it come to be defined in this way? What is the life history of the problem?

Reflective practice involves consideration not only of what we mean by 'reflective' but also of what assumptions we have about 'practice'. Given the contemporary emphasis on 'evidence-based practice', we are drawn into a number of assumptions about the practice of psychotherapy and counselling. In summary, this approach regards clinical work as a process whereby we undertake a systematic assessment to identify what the 'problems' are. Next we turn to the research 'evidence base' to guide us about the best form of treatment indicated for the type of problem(s), for example, choosing CBT as the proven choice of treatment for depression (Roth and Fonagy 1996).

Schön more broadly describes and critiques this approach, which he terms 'technical rationalism', and which is embodied in the ethos of evidence-based practice – that research will provide definitive answers about what types of interventions and treatments are most suitable for various clearly defined problems. Clinical practice would then be reduced to applying established techniques in a rational way to identified problems:

Technical rationality depends on agreement about ends. When ends are fixed and clear, then the decision to act can present itself as an instrumental problem. But when ends are confused and conflicting, there is as yet no 'problem' to solve. A conflict of ends cannot be resolved by the use of techniques derived from applied research. It is rather through the non-technical process of framing the problematic situation that we may organise and clarify both the ends to be achieved and the possible means to achieve them.

(Schön 1983: 41)

These arguments connect with the complexity and uniqueness of clinical work. Many clients show multiple problems, referred to as co-morbidity; for example they are not just depressed but also anxious, isolated, using drugs and alcohol, and so on. More than this, we may find that problems, if we are willing to recognize this, change and alter. If we are able to work across models we might see that 'depression' is also linked to marital problems, or conflicts at work, and that what appeared initially to be 'the problem' shifts dramatically. Here reflective practice is intimately linked to the concept of formulation which involves drawing up a set of explanations or hypotheses about the nature and cause of the problems presented and, in turn, what might be helpful in responding to them (Johnstone and Dallos 2006). A fundamental aspect of formulation is a deconstruction of the 'problem'. This involves a critical appraisal of how the problem is initially defined and explained, along with a consideration of possible alternative explanations. Importantly, decisions are made about whether the problem is to be considered as an individual phenomenon, as something residing within the individual, or as interpersonal and relational, caused and maintained by ongoing relational processes. Moreover, the process of formulation is not a rational, dispassionate affair but involves the clinician both as a professional and a person with her own unique emotional history and experiences which influence the process of formulation.

Psychodynamic approaches in particular have, from the outset, emphasized the importance of the therapeutic relationship. We can argue that it is within a growing, changing, evolving relational context that some definitions of 'what the problems are' start to emerge. Within a social constructionist framework they are seen as being co-constructed within a wider cultural landscape of shared ideas and discourses, for example of what are

normal, appropriate, legitimate ways of being a person, couple or family. When therapists choose to adopt a particular model or style of practice, their attraction to a method of working is often influenced by the values they hold and their wish to take a moral and ethical stance in relation to their clients. There is a human component to their choice that goes beyond simply following a set of prescriptions arising from a rational evidence base. In each of the chapters in this book we see that different approaches to psychotherapy and counselling have a theoretical coherence that guides clinicians in their moment-by-moment decision-making, yet draws their attention to different features and aspects of the problem under construction.

Schön describes three ‘zones of indeterminate practice’ – the unique, the unexpected, and value conflicts – that fit so far with our deconstruction of the way in which clinical problems present. Each individual clinical case is unique in its own right and clients often reveal fresh and unexpected information as the problem is explored. Sometimes, as clinicians, we feel in uncomfortable places when our own beliefs, such as not hitting a child, or valuing men and women equally, are challenged and our values may not be shared by our clients. Schön argues that these indeterminate zones are the territory of the ‘swampy’ lowlands and that we come to inhabit them by learning through our experiences, rather than slavishly following theoretical knowledge. In fact, to tackle the complexity presented by clinical problems, we have to derive at least some of our theory from practice. Through tolerating the ambiguity and uncertainty that casework presents, we learn how to navigate our way through therapy. This ‘learning by doing’, or coming to rely on practice-based evidence, draws on past experience and contrasts with the idea that we can learn our skills through following a set of guidelines. There is no such easy way to ‘know that’ we are doing the right thing. In clinical practice, we recognize the contrast between application of knowledge and competencies on the one hand, and an ongoing fluid interacting process between the practitioner and clients on the other.

Acquiring clinical skills: Knowing in action

Most educational curricula are designed to be developmental and progressive to assist staged learning: we teach our children the letters of the alphabet before we build them into words, and piano players practise scales so that they can build up their musical skills gradually. Yet, once we move away from the relative safety of role-play or problem-based learning approaches using simulated case scenarios, the trainee therapist must step into the swampy lowlands of clinical ‘messiness’. Acquiring clinical competence necessitates working with complex situations from the outset. As all good trainers are aware, there is no such thing as the truly ‘simple’ case, hand-picked for the

uninitiated trainee therapist! She must learn to think on her feet, to tolerate uncertainty and ambiguity and to 'feel' her way through emotionally demanding and challenging difficulties that her client brings to her.

Therapy and counselling can be seen as skilled activities. We may disagree whether therapists and counsellors need to be seen as 'experts', but there is widespread agreement that the activities require the development of some expertise. We may prefer to call this the accumulation of experience rather than a skill. However, either way, we can suggest that there are similarities to the learning processes involved in the development of other skilled activities. Over time we appear to develop some unconscious or semi-conscious processes whereby we can perform activities, such as driving a car, with less ongoing conscious awareness. This has been called 'procedural learning', whereby we learn to perform sequences of increasingly complex actions in an almost automatic fashion (Stadler 1989; Willingham et al. 1989; Schacter and Tulving 1994). Schön refers to this set of procedures we acquire for performing skilful and routinized activities as 'knowing-in-action'. Such knowledge appears to be mostly unconscious, and it can even be disruptive to become consciously aware during the performance of such sequences of actions.

Clearly we would not want to suggest that therapy and counselling can simply be reduced to producing fixed sequences of skilled behaviour. Even riding a bicycle involves monitoring the environment and being able to adjust when something unexpected happens. When something goes wrong, we may need to make conscious decisions to correct the problem. At these points we can oscillate between attempting to override the learnt patterns but also be governed by them, sometimes resulting in indecision or vacillation. Reflecting on such 'knowledge in action' can momentarily break the spontaneous flow of familiar and rehearsed procedures and could possibly be dangerous. For example, when driving a car it is important that stopping in an emergency is instantaneous, not carefully planned and executed according to a set of written guidelines. And yet it is equally important for our learning that we take time out to reflect on our performance, practising expansions to our repertoire and honing our technique.

Reflection 'in' and 'on' action

Becoming aware of what we do implicitly often occurs when something surprising or disruptive happens, such as a client or family having an unexplained angry or critical outburst. Schön calls this conscious direction of our thinking towards immediate practice, 'reflection in action'. So the novice therapist, encountering this disconcerting experience for the first time, may question what just took place, feeling anxious and uncertain about what to

do or say next. Following Schön, we might call this reflection *in* therapy, signalling that it is an ongoing process. Bleakley (1999: 319) reminds us that such spontaneous reflection 'is a "hands on" business, rooted in the immediacy and heat of practice, the sticky moments of indecision, feeding on sudden shifts in circumstance – the unique and irregular – and forcing improvisations and risk'.

Indeed, in the heat of the moment, the novice therapist might well try out something new, drawing perhaps on past experience, or remembering a teaching session on anger management. It would then be very important to take time out retrospectively to reflect upon whatever happened next, in order to learn from this experience. Schön calls this more measured process of looking back on a situation in order to make sense of it and deal with feelings that arose, 'reflection on action'. In practice, this reflection 'on' therapy often takes place during supervision, perhaps exploring what happened with the supervisor through the use of notes or a piece of video or audio tape. With supportive supervision over time, we might come to view this overt expression of anger as a common stage of therapy, a process of projection or an authentic expression of feelings, that allows us to respond calmly, allowing the person space and time to consider what the communication was about. Eventually this practised response will become part of our 'intuitive' repertoire. Indeed, Schön himself chose to analyse a psychotherapeutic supervision session in order to draw out some of the reflective processes that contribute to practising and learning about therapy.

In practice, the distinction between reflection 'in' and 'on' actions may not be so straightforward (Ixer 1999). In the process of therapy there may be periods where we are connected and attuned to the interaction with a client or a family. This can be described as intersubjectivity or as a form of 'co-presence' where we are not aware of being separate from them while we are lost in the moment of active listening and engagement. We may become aware of some discrepancy or problem and reflect in the moment to try and figure out what this is and respond appropriately. However, we can also sit back somewhat from what a client is saying and not be so fully connected with them, whereby to some extent our reflection moves more towards an 'on' action state. In the systemic therapies and, arguably, group therapies this can occur more easily, for example, as a family start to talk amongst themselves and the therapist 'sits back' to observe and reflect on their process with each other and with him (see Chapter 8). The balance between how reflection 'in' and 'on' action occurs during the process of therapy, or in later supervision, also varies across the therapies as to how it is structured into the process. The systemic therapies typically involve reflection *in action* through the use of forms of live supervision, such as in-room consultation between therapists or the use of team reflective discussions in front of the family or couple. Also, though now less common, live supervision could be provided

by means of phone calls from the supervisory team during a session. These reflections occur during therapy but arguably are somewhat more detached than an immediate reflection *in action*. As Ixer (1999) suggests, we may move in and out of these states of reflection, to some extent paralleling our states of consciousness or intersubjective connection with clients.

We have argued that therapeutic competencies cannot be taught progressively in a linear, instructional manner. One approach is to foster abilities to improvise by learning models, such as problem-based and experiential learning. There is a vast literature on experiential learning across many educational and professional settings that we cannot do justice to here (Moon 2004). Kolb's (1984) experiential learning cycle closely follows Schön's notion of 'reflection on action' and describes the importance of reflecting upon earlier experiences in order to transform them into a deeper level of understanding. New learning is acquired through reflecting on action. Kolb asserts that such learning involves the whole person, including thoughts, feelings and senses, and acknowledges that the learner's life experiences are actively used in the learning process. Boud et al. (1985) also recognize that learning in this way is a holistic process and that the process of learning itself is influenced by the socioemotional context in which it occurs. This is essential to remember in relation to learning about therapy, where the domain of knowledge is concerned with understanding the human condition, including all aspects of thoughts, feelings and actions. Throughout this book the importance of reflective thinking in the acquisition of therapy skills is acknowledged, though the content of supervisory reflection and the construction of theories to account for clinical experiences will vary across the different models.

In general, by regularly exposing ourselves to the challenge of having to solve different problems we start to acquire a set of higher-order and less easily measurable or identifiable competencies (Roth and Pilling 2007) that describe our 'knowledge in action', to use Schön's terminology once again. Central to this learning is an interplay between conscious learning and the gradual internalization of procedures, leading to unconsciously held skills. By analogy to learning to drive a car, most of our initial learning takes place at a conscious level, as we step on the clutch before we change gear. However, with good teachers we gradually internalize these skills so that we can eventually perform them without conscious awareness. Consistent with this, the amount of verbal instruction provided by the instructor gradually decreases, with more and more time being dedicated to the practice of the skills with occasional reflections and guidance offered to make corrections. This analogy, of course, breaks down if we had to deal with cars that had minds of their own! We shall turn next to consider what might prompt key moments of reflection in the context of practising therapy.

When should we use reflection? ‘Yawns’, ‘ahas’ and other reflective moments

When does reflection happen? Earlier we suggested that ‘aha’ moments, when something unexpected happens, may naturally prompt our reflective curiosity. However, we also want to acknowledge here that ‘yawns’, or moments of apparent boredom, when we experience complacency about our practice, should equally prompt us to reflect on our ‘taken-for-granted’ practices.

Neuropsychology has shown that a constant, unvarying source of stimulation will eventually not be registered. For example, if a static array of light from an object is presented to the retina, while preventing the eye’s natural tremor (stochastic eye movement), the brain eventually fails to process the information and ceases to recognize the object. This effect has also been called ‘news of difference’ and suggests that we are pre-wired to respond to change and variation in our external environment. By analogy, our reflective functioning also appears to be prompted by difference – the unexpected, the unusual and the unpredicted. When things are going steadily to plan, we do not need to reflect. We can see that reflection, then, is closely tied to attentional processes of monitoring and vigilance. We monitor aspects of our experiences that are most likely to be unpredictable, risky and dangerous more closely. This may have evolutionary value, both allowing us to proceed with routine and familiar tasks without overwhelming us with constant reflection, while equipping us to remain alert to the threat of change.

However, reflection appears to be more than this. One aspect of reflection may be that we can reappraise what we should attend to by altering our attentional set. We can also recalibrate our attention by making decisions as to whether we need to be less or more vigilant to certain aspects of our experience. This offers a relatively pragmatic account of reflection and when it occurs. However, it does not seem to embrace the whole picture. From other sources, for example, attachment theory (Bowlby 1988; Fonagy et al. 1991; Main 1991) there is evidence that the capacity to be reflective, over time, is facilitated by a background state of calm and safety (see Chapter 2). Hence it is not only triggered by the unexpected, or threat or danger. There may be times when we are feeling quite relaxed and not immediately prompted by some discrepancy in our expectations and predictions. This kind of reflection is more akin to musing, daydreaming or ‘contemplating our navel’, a kind of self-absorbed feeling of simply being ‘in the moment’. One possibility is that from a ‘safe base’ we are able to go back over events, to *reflect on* things that, in the heat of the moment, were too difficult to process. Another possibility may be that thoughts can arise unexpectedly, perhaps breaking through the defensive mechanisms that we have developed to keep

painful experiences at a distance. In quite safe moments we may 'let our guard down' such that some memories break through. Or perhaps in these safe moments we invite ourselves to re-experience more traumatic memories that require our further reflection.



Figure 1.3 Thinkers, thinking about the thinker thinking ...?

However, in these accounts, like Rodin's statue, we may be overly privileging reflective processes as something individual and internal. Perhaps the greatest prompt to reflections lies in social engagement through conversations, reading, movies, watching television and so on, when we are exposed to the thoughts of others. Although, we can make choices about what we talk about, with whom and what we watch, read or attend to, unless we live in lonely isolation, it is very likely that we will be prompted to reflect on our experiences, relationships and life in general. Even if we try to avoid issues that are uncomfortable for us, there is now a massive industry of psychological material aimed directly at making us reflect. For example, the media abound with documentaries about psychological issues and popular psychology, chat shows about relationships and observational/reality TV programmes. Of course a question remains whether these promote much in the way of profound or significant reflection, or whether this needs to be closely linked to our personal experiences.

Complacency monitoring – reflections in and on action

As we gain expertise as therapists and counsellors, we also develop propositional frameworks for understanding situations that we have commonly encountered. This equips us with a set of generalizations that we can apply to new situations, by drawing on past experience. For example, JS has specialized in working with many families where the presenting problem is medically unexplained pain. Likewise, many clinicians have areas of expertise with particular client groups or types of problem. It is arguably necessary and efficient to assimilate some commonalities and draw out some generalizations based around clusters of related experiences. These schemas or belief systems may develop in a relatively gradual and amorphous way so that we cannot easily put them into words. By analogy, physicians may develop some intuitive judgement about when the shape of a tumour is indicative of cancer, as opposed to benign. These accumulated packets of experience can be helpful and contribute to our clinical wisdom. However, they can also be dangerous if they lead us to rigid thinking or to becoming complacent. For example, I (JS) may be tempted to see the child with unexplained pain as expressing emotional distress on behalf of the family, ‘yet another’ example of symptomatic behaviour serving to regulate conflict within the parent’s marriage. Such assumptions, though accumulating from our past experience, may blinker us to noticing information that does not fit with our expectations, leading to the well-known ‘self-fulfilling prophecy’ effect. We have termed an invitation to reflection here as a ‘complacency monitor’. By this we mean that it is possible to see a cycle whereby intuitive action and reflection are connected in a continual loop (see Figure 1.4).

This summary emphasizes that we need to be proactive in taking time out to reflect – to examine, explore, critique, re-evaluate and generally update our procedural/intuitive knowledge in order to resist the comparative safety of complacency. Again by analogy to skills learning, many drivers report that, over time, they develop some ‘bad driving habits’, such as braking or signalling too late. Not only do our shortcomings unsettle us but similar phenomenon can be very shaming when we watch live recordings of ourselves as therapists. How many of us would rediscover some ‘bad habits’ such as offering interpretations too early, not listening closely enough, or worse still, speaking over or interrupting someone who is trying to say something? In the proceeding chapters we will learn more about how different models of therapy and counselling address complacency or ‘bad habits’ monitoring.



Reflective Practice:
Reflection *in* and *on* action

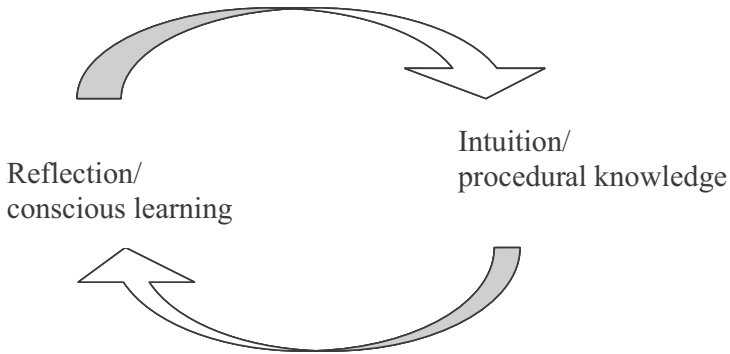


Figure 1.4: Complacency monitoring

The content of reflections: From subjective self-awareness to reflexive thinking

So far we have considered reflective practice to be a set of procedures that assist in both the learning and skilled practice of therapy. Implicit in this account is the idea that reflecting involves thinking about, and conscious awareness of, what we are doing and why we think we are doing it. In this sense it is an intellectual activity and, as far as we can tell, this capacity to think about thinking (referred to in the psychological literature as ‘metacognition’ (Flavell 1979; Main 1991) is most advanced in our human species. We shall be exploring the biological basis of reflective functioning in the next chapter, but linked to this is the idea that we can utilize both verbal and non-verbal cognitive processes to formulate the content of reflecting both in the here-and-now and in ‘looking back’ over our experiences.

All the therapy models explored in this book assert that therapists should have a high level of self-awareness, so that they are attuned to thoughts and feelings engendered in them during the process of therapy and can make sense of these within the particular theories that underpin their

practice. Indeed, many models require that the trainee therapist turns the spotlight of reflection, as it is practiced within the designated therapy, upon themselves. For example, psychodynamic psychotherapy insists that the trainee therapist undertakes thorough self-analysis in order to gain insight into their own unconscious processes (Chapter 4). CBT emphasizes the importance of 'self-practice/self-reflection' as an experiential approach to training (Chapter 7). According to George Kelly (1955), the founder of personal construct therapy, it is essential that 'practitioners and researchers see themselves in fundamentally the same way as they see the people that they are studying or helping (Chapter 6). Cushway (Chapter 5) explains that 'conscious experiencing' at many levels is the bedrock on which humanistic therapies are founded. Humanistic therapists are taught to pay great attention to their own process and to track and monitor their own awareness by practising on each other: 'It is impossible to explain to others or to really understand what is meant by levels of awareness unless one has experienced them for oneself.' Systemic therapists now pay far more attention to the need for trainees to explore their own families of origin and to deconstruct their values and beliefs about family life (Chapter 8). Finally, narrative therapy (Chapter 9) highlights the importance of locating ourselves, as ethical practitioners, within the wider social, cultural and political contexts that influence the stories and discourses we engage in with others.

From this brief summary we can already see that reflective practice is multi-layered, concerning itself as much with sensory and bodily experiences as with verbal and higher-level intellectual cognitive processes. Research from cognitive neuroscience (Tulving 1972; Neisser 1993; Schacter and Tulving 1994; Tulving and Craig 2000) suggests that we encode and store our experiences in terms of various memory systems: procedural (learnt unconscious actions sequences), visual and sensory memory, semantic (conceptual) memory including propositional knowledge, episodic memory (sequences of events over time), stories and narratives, and finally a working or executive memory. It is probably the latter that we immediately think of as encompassing reflective processes, corresponding to 'reflection in action' as described earlier in this chapter. But it is important to bear in mind that this executive/integrative memory uses material from the other systems and is not simply or predominantly verbal. When sharing the content of our reflections, verbal language provides a medium for quickly sharing our thoughts and feelings in terms of concepts and stories. But we can also draw on other symbolic representations such as signs and images. In this sense, if we engage in reflective thinking which is exclusively verbal we may not be integrating experiences that are held, for example, as visual and which may carry considerable emotional impact. Often unprocessed past traumas may be held entirely in emotionally embodied, sensory memories, too overwhelming to translate into language for sharing. Reflective therapists need to

be able both to access and to process material represented within these different domains and draw on them in a balanced way. On the one hand, verbal and logical reflection alone may be described as overly abstract or 'head in the clouds'. On the other hand, reflection which is overly visual and emotional may be seen as too emotive and irrational.

A landscape of reflective practice

As we contemplated these various meanings and uses of reflection, we began to play with ideas for positioning different models in relation to one another. Before you embark on reading the chapters that follow, we invite you to consider some options for making sense of the descriptions of reflective practices that are provided.

Drawing on the distinction between personal and epistemological levels of reflective practice, we came up with a two-dimensional model, providing a space for 'locating' different therapeutic models. This was a kind of *Gedanken*, or 'thought experiment' and we invite you to try it out by thinking about a model that is familiar to you. The first dimension represents the extent to which the model explicitly incorporates personal reflectivity within guidelines for its practice. Such reflection by the therapist may be propelled more by immediate, subjective experiences or might include awareness of relational power and inequalities influencing the therapeutic relationship. The second dimension represents epistemological reflexivity; that is, the extent to which the model explicitly includes a theory about reflection that maps out the content and meaning of reflective practice within propositional terms. This could include ideas about the content of reflection, for example what aspects of ourselves, our current, developmental and family experiences are important areas for reflection. It covers whether reflection is built into supervision, is continuous (reflection 'in' action) or retrospective (reflection 'on' action). Included in this second dimension is the extent to which models describe specific practices or techniques which are aimed to foster reflection as part of training, the practice of therapy or in supervision.

As an experiment, we attempted to contrast a pure existential technique such as the practice of mindfulness with a highly discursive post-modern account of social constructionism (see Figure 1.5). Our suggested dimensions are not at all simple or straightforward. How would we situate 'mindfulness' if it was being used as part of an overall CBT approach? How might the actual practice of 'postmodern' narrative therapies appear different from the complexity of social constructionist theorizing? Nor are we suggesting that these dimensions offer the 'best fit' for this hypothetical exercise, but they do provide a starting point for exploration of our models.

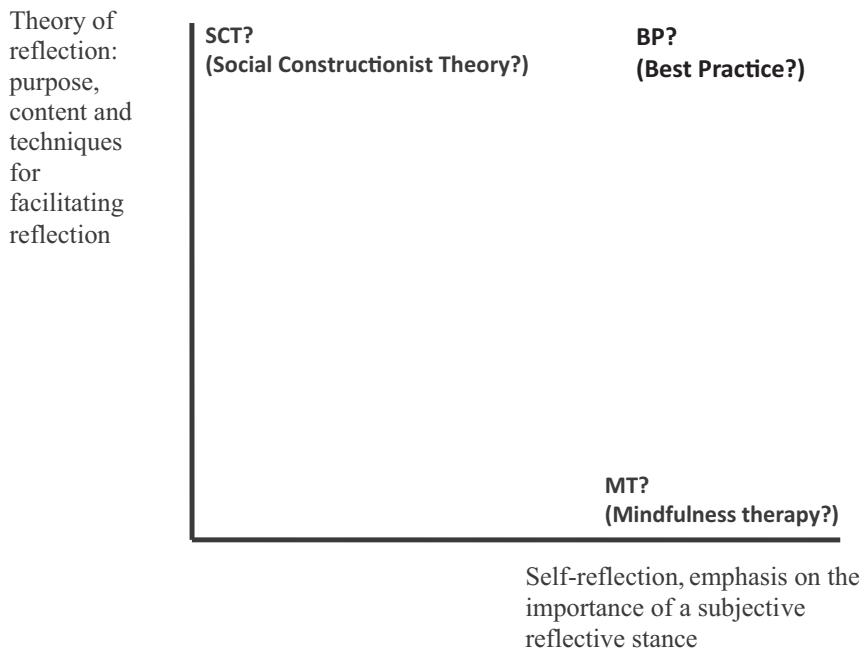


Figure 1.5 A tentative framework for reflecting about therapeutic models

We have asked colleagues to consider where their preferred model of practice might lie, and at once their passion for and commitment to particular ways of working become evident. Interestingly there appears to be an underlying assumption that the top right-hand corner of this 'space' might in some ways characterize models of 'best practice', yet we do not know whether some models might incorporate too much or too little reflective practice. It seems more likely that both therapist's and client's choice of preferred therapeutic models fit with their wider ideological, spiritual and political beliefs. For example, if we are generally uncomfortable with expressing or thinking about our own emotions, we may be more comfortable with therapeutic approaches that are more structured and procedural (Winter 2003). In contrast, the more expressive therapies may feel more comfortable for those of us who are less restrained in expressing our feelings in our personal lives.