**Reflective Paper on Assignment Role Plays**

Andrea M. Garraway

Department of Counselor Education and Family Studies, Liberty University

**Reflective paper on Assignment role plays**

Section I

Client Role: a) what was it like role-playing a client? (b) How did it feel to experience the structure and process of CBT and how it was or was not helpful? Why?

In careful preparation for my role, as the client, I rehearse my lines by going to the DSM 5 to review several psychological disorders. I wanted to display a range of criteria that would lend to both a primary and differential diagnosis. At the inception of the session, although I worked to get my mindset in the role of the client, I struggled a bit during the beginning moments of the session. This was evident and maybe even predictable by Dr. Sibcy. In the awareness of this, I settled into my role, aligning my mindset with the therapeutic framework. As the session progressed my answers transition from more of intellectual response to an emotional one. It was at this point, I began to experience, what I reflected on, as the cognitive impact of the CBT techniques and interventions employed my therapist. According to our text, emotional activation is proposed to be a necessary component of new learning and therapeutic change. My experience was powerful, cognitive, and effective change. I reflected on my need and motivation that will lead to behavioral change. The benefits from the CBT skills created and promoted cognitive flexibility within me. I found this to be a very helpful, functional, and an affective experience.

Section II

Therapist Role: (a) How did you experience the role of the therapist using these skills? (b) How do you see yourself incorporating these skills and strategies into your theory of counseling?

During my time within the therapist role, I experienced three stages of comfortability. Firstly, I was not comfortable at all but grounded myself in knowledge acquired from the pre-intensive reading. I was readily able to identify erroneous thoughts pattern and techniques needed to combat them. This led me to a *shaky* comfortability. Following this, I felt myself settling into the role and experiencing the ease of therapeutic flow. This stage can be considered *home*. During this stage, I felt like I was at my peak of zoned comfortability, by Wednesday of the intensive week. The final phase is the *retrieval* stage and it was entered on Friday afternoon. I experience both elation and relief in this stage. Overall, I can attest that the application of the clinical skills met treatment expectancy. One of the positive outcomes from the experience within the therapist role is a sense of added credibility. I was able to demonstrate this efficacious treatment within an environment that is specifically tasked with evaluating implementation, fidelity, and nuances on the counselor in training (me). The indirect and the direct feedback were insightful and was well received. I was grateful for this opportunity to learn and for future application, modification, and adjustment to my CBT abilities.

An interesting contemplation throughout my retrieval stage began during my settling into the role of the client and these thoughts resurfaced during my reflection as my role as the therapist. I pondered if CBT is all about changing one’s perception and thoughts which will consequently change their behaviors, would it be safe to say, that the therapist subscribes to this same school of thought. If so, the therapist administering the CBT techniques already believes within their perception that it is going to work. Does this subjectivity influence reliability and validity to the outcome? Additionally, does this variable of individual subjectivity serve as a predictor of CBT improvement outcome and are these result consistent?

I am grounded in the counseling principles of Humanistic and Rogerian theories. Developed over time is my broader personal theory of counseling, which includes the amalgamation of several other theoretical perspectives. While I consider myself a Humanistic- Rogerian, I grew in the understanding that different presenting problems require different counseling techniques and skills to address them. This requires a working knowledge and proficiency in several other areas. A part of being person-centered promotes the ability to amplify positive and negative affect. I am interested in integrating most-all the CBT skills acquire during this course (now that I know how to employ them with fidelity).

I learned ways to generate stronger emotional responses from my clients and supervisees compared to verbal-linguistic thinking. With these new tools, I can help to increase the general consciousness of frequently occurring or spontaneous negative thoughts by paving the way to enhance their own recognition of these cognitive distortions. Resulting from the practical exercises I am beginning to feel comfortable working with problematic thinking which is linked to emotional difficulties. Within my role as the supervisor, I would function as the teacher of these dexterities, as opposed to the counselor implementing these skills as I would when working with a client. When delivering services to both my supervisees and clients I am certain that there is little room for coddling the client, as the directive approach is encouraged.

Section III

Observer Role: (a) How did you experience yourself in the supervisory role? (b) Did you find the structured rating form helpful? Why? (c) What would you change about it to make it better? (d)

I was not as comfortable as I initially thought that I would be (I felt vulnerable). As I settled into the role, I recalled some basic skills and added those skills set into the experience. I was inspired by Beck the mentor to orient myself with a curious mindset, be aware of my mood, learn to benefit from the environment while being collaborative, generous, and kind to empower my supervisee (Leahy, 2006). The structure rating form was helpful to record my experiences during the session but more-so to recall the insightful interaction after. Presently there is nothing I would do to improve this process to make it better.

Section IV

integration: (a) Reflect on how the CBT skills you practiced could be modified and adapted to apply to at least two minority populations. (b) describe what part of CBT seems to be most consistent with a Christian Worldview (CLOs: 3,4,5,8)

Using the framework of CBT could potentially have many beneficial applications within the Christian worldview, as both services as behavioral change agents. A parallel is drawn between cognitive behavioral therapy (CBT) and the Christian worldview, which I would entitle, spiritual behavioral transformation (SBT). While the premise of CBT is to change thinking to change behavior, SBT aims to change our hearts to change behavior. The interventions of SBT activates by accepting God and allowing His Word to regenerate our minds. The fruits of the spirit or changes in one’s behavior are displayed through love, joy, peace, forbearance, kindness, goodness, faithfulness, gentleness, and self-control. Against such things, there is no law. Galatians 5:22-23 (INV).

The only caution when integrating secular and religious constructs derives from an individual’s definition of their Christian worldview. When applying CBT and SBT we can establish functioning demarcation when misinterpreting or categorized based on our interpretation of Christianity. For example, a Bosnian Christian may see his religion and world view as different from a Christian in America. Who then may also see things differently from a Christian such as James Cone who used his world view to create a “Liberation Theology” within his understanding of what Christianity states, “it is ironic that America, with its history of injustice to the poor, especially the black man and the Indian, prides itself on being a Christian nation.” A theological study of the variant identities within the Christian world view is beyond the scope of this work using CBT. However, we must be nuanced enough to account for these differences while giving a framework for the application of CBT techniques and their applicability for use in the aforementioned minority populations Black and Indian.

Symptoms such as PTSD, sexual and relationship problems, phobias, habits, and mood swings affect all of the human family regardless of the particular religious view held by the individual. As a clinical profession, we can adapt any particular framework to suit any world view based on the needs of the patient. So, the consistency of using CBT within the Christian framework must be grounded in an understanding of the particular person’s religious belief and world view as seen by that individual, not the group.

Andrea, you made some good points in your paper. I would like you to tease out your points with specific, concrete examples. Also, keep in mind, cbt is much more sophisticated than simply change thinking change behavior. you left out the critical thinking emotion link. also, cbt looks to change behavior to change thinking and emotion. I made several long comments in your paper, be sure to check these out.﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿﻿

94/100

Reference

Newman, C. F. (2012). Core competencies in cognitive-behavioral therapy: Becoming a

highly effective and competent cognitive-behavioral therapist. New York, NY:

Routledge.

Leahy, R. (2006). Contemporary Cognitive Therapy: Theory, Research, and Practice

Guilford Press: New York.