The Importance of Identifying and Understanding Therapist Schema in Cognitive Therapy Training and Supervision

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The cognitive therapist's ability to identify, reflect upon, and constructively utilize, the content of his or her beliefs, assumptions, emotions, and behaviours which may be triggered by the interpersonal process occurring in the therapeutic relationship, is increasingly seen as an important part of a successful treatment outcome in cognitive therapy (Safran & Segal, 1996). Identifying "therapist schema" (Leahy 2001) is one mechanism which can be used in training and supervision to facilitate understanding more about how these factors may impact on therapy. Four groups of Cognitive Therapy trainees completed the "Therapists' Schema Questionnaire" (Leahy, 2001). A clear pattern emerged which showed the therapist schema; "demanding standards", "special superior person", and "excessive self-sacrifice" to be the most common schema identified in all four groups. This paper highlights some of the potential therapy interfering effects of therapist schema using the schema listed above. Practical suggestions consistent with the cognitive therapy model are proposed as useful supervision strategies with which to help trainees identify and understand their schema, in the context of the therapeutic relationship.

Cognitive Therapy (CT) has expanded over the past 15 years and treatment protocols for the treatment of increasingly complex and chronic diagnostic presentations such as the personality disorders have been developed (Clark & Fairburn, 1997). This has resulted in longer periods of treatment and a modification of some CT treatment protocols to include an increased emphasis on the interpersonal aspects of the therapeutic relationship as a treatment intervention (Beck, Freeman & Davis, 2004; Young Klosko & Weishaar, 2003). The cognitive therapist's ability to reflect upon and constructively utilise the interpersonal processes manifesting in the therapeutic relationship is identified as an important factor in successful CT treatment outcome (Safran and Segal, 1996). The converse is also true in the sense that a lack of therapist insight regarding personal interpersonal process can result in mistakes being made in treatment (Young, Klosko & Weishaar, 2003). Facilitating the ability of the therapist to reflect upon the therapist's own contribution and response to the interpersonal process is therefore an important part of training competent cognitive therapists (Leahy, 2001). In this paper some of the conceptual changes regarding the therapeutic relationship in CT are discussed, and a number of techniques which can be used in the training and supervision of cognitive therapists to facilitate the trainees' understanding of the impact of their own interpersonal process on the therapeutic relationship are summarised. The Therapists' Schema questionnaire (Leahy, 2001) is used as a practical example of a technique which is conceptually compatible with the CT theoretical model.

The relative importance of the therapeutic relationship is widely acknowledged in most established psychotherapies (Bachelor & Horvath, 1999). Behaviour therapy (BT) and cognitive therapy (CT) have, in the past, been exceptions to this trend, placing more emphasis on the application of the specific techniques derived from their respective models (Wampold, 2001). An example of a specific technique would be the use of the "dysfunctional thought record" (Beck,1995) in CT, or graded exposure to a feared situation in BT. In CT and BT, a good working relationship is seen as an important background or non specific factor. Recently, the idea that the therapeutic relationship is secondary has been challenged by CT therapists working with complex diagnostic presentations, such as the personality disorders, where maladaptive interpersonal relationships are a defining characteristic of the disorder. When working with these patients the therapeutic relationship is increasingly seen as the vehicle through which alternative more adaptive patterns of relating can be explored. In this context the psychoanalytic concepts of transference, counter transference, and resistance have been revisited by some cognitive therapists (Layden, Newman, Freeman & Morse, 1993; Linehan, 1993). This has resulted in some efforts to re-conceptualise these processes

so as to fit more comfortably with the fundamental principles of CT (Leahy, 2001; Rudd & Joiner, 1997, Young, Klosko & Weishaar, 2003).

In psychoanalysis, counter transference referred to the unconscious projections by the therapist onto the patient, of unresolved past developmental conflicts. In contrast, CT rejects the notion of the "unconscious", emphasises the importance of the present, and highlights the interaction between cognition, affect and behaviour with the emphasis on cognition as the mediating factor. In this context counter transference is given a broader definition and is seen as the therapist's cognitive, emotional, and behavioural reactions to the patient which are conscious and accessible to the therapist. It is suggested that the identification and understanding of these reactions can be used constructively in CT, as they are likely, in many instances, to mirror the type of interpersonal process experienced by the patient in relationships outside of therapy. The therapist needs to develop the ability to observe his or her reactions objectively so that the signals can be processed in a manner which expands the patient's understanding of the interpersonal relationship which can then be productively generalised to "real-life" situations outside of therapy. Conversely, if the therapist ignores, or fails to understand his or her emotional reactions (counter transference), negative therapy interfering consequences can result; for example, technique avoidance, guilt or fear over patient anger, feelings of inferiority, the inability to set limits, overextending the therapy hour, inhibition regarding the discussion of sexual issues, and anger at the patient (Leahy, 2001).

These developments suggest that an important aspect of training and supervising cognitive therapists is encouraging trainees to become aware of the impact of their counter transference. Leahy (2001) suggests some simple guidelines that may help in the understanding of counter transference. In the first instance simply acknowledging that the phenomena exists is important in CT, which traditionally places emphasis on treatment manuals and protocols that emphasise specific factors at the expense of relationship (non specific) factors. Secondly, noticing the different levels of arousal triggered by different patients or types of problems can predict particular associated belief patterns and behavioural responses. For example, patients who are dependent may trigger over-involvement or withdrawal from some therapists, depending on the personal beliefs of the therapist. Thirdly, becoming aware of personal schema which manifest in the trainee's everyday life situations is helpful as situations in therapy can trigger these habitual responses. For example, if the therapist has a fear of abandonment, discharging clients from therapy may be difficult. Utilising this awareness in a therapeutically helpful way requires that the trainee understand his or her reactions in a manner conceptually consistent with the CT model. To do this the trainee needs to develop an awareness of his or her negative automatic thoughts, underlying assumptions, and core beliefs or schema as triggered by the therapeutic relationship.

The "Therapeutic Belief System" (TBS) (Rudd & Joiner, 1997) is a CT conceptual model useful for understanding the particular types of beliefs, assumptions and behaviours commonly experienced by therapists and patients which could potentially affect the course of therapy. The TBS sets out a framework to identify the therapists' and patients' beliefs about themselves, each other, and the course of treatment, the emotions these beliefs may trigger, and typical behavioural responses. For example, the therapist may see the patient as a "hostile aggressor", "helpless victim", or "collaborator". Each one of these beliefs would result in a different emotional and behavioural response. For instance, perceiving the patient as a "helpless victim" might precipitate an anxious or depressed emotional response in the therapist, resulting in over-cautious or excessively nurturing behaviour which could manifest in avoiding using appropriate treatment interventions such as exposure to feared situations.

Practicing CT techniques and interventions on oneself as therapist and reflecting on the outcome of this, is another potentially helpful way to increase the trainee's awareness of his or her counter transference. Useful interventions could include monitoring mood in relation to situational triggers, completing a personal functional analysis using a five-part model (Padesky & Mooney, 1990), completing a dysfunctional thought record (Beck, 1995), or devising and reflecting on the outcome of behavioural experiments. Other useful self-practice could be the completion structured questionnaires commonly used to identify schema, core beliefs, and underlying assumptions. Some examples are the Dysfunctional Attitude Scale (Weissman & Beck, 1978), the Personal Belief Questionnaire (Beck & Beck, 1995), the Young Schema Questionnaire (Young & Brown, 2001), and the Therapists Schema Questionnaire (Leahy, 2001).

In this paper, the Therapists' Schema Questionnaire (Leahy, 2001) is used as a relatively simple screening technique to identify therapist schema which could impact on the therapeutic relationship. Once identified, therapist schema can be used in supervision as a starting point for discussing some of the trainee's potential counter transference processes within the context of the CT model. A schema refers broadly to mental structures which integrate and give meaning to events (Beck, Freeman, & Davis, 2004). In this context schema can be positive, negative, or neutral. In CT, schema are usually described as dysfunctional and are often associated with specific diagnostic presentations. For example, schema over-estimating personal vulnerability and external threat are common in the anxiety disorders (Beck & Emery 1985). The following definition describes the way in which schema operate in CT: "A broad, pervasive theme or pattern, comprised of memories, emotions cognitions and bodily sensations, regarding oneself and one's relationship with others, developed during childhood and adolescence, elaborated through one's lifetime and dysfunctional to a significant degree" (Young, Klosko & Weishaar, 2003). "Therapists' schema" have a similar dysfunctional connotation. They are however, less pervasive and unconditional, are triggered in certain specific, therapy related contexts, and do not usually signal mental health problems. Therapist schema are

influenced by factors such as training experiences and supervision, stage of training, clinical experience, peer group, psychotherapy model, and personal experience. Some examples of therapists' schema identified by Leahy (2001) are: "demanding standards" (an obsessive-compulsive approach to the patient's performance in therapy usually involving high expectation of compliance); "abandonment" (concern about being "abandoned by the patient); "need for approval" (people pleasing); "excessive self sacrifice" (the inability to set appropriate boundaries or act assertively with patients); and "special superior person" (an over-inflated or grandiose view of one's therapeutic skill).

Method

Participants

The participants were four groups of trainees enrolled in the Massey University Post-Graduate Diploma in Cognitive Behaviour Therapy (CBT); groups A (n = 16), B (n = 26), C (n = 14), and D (n = 8). The Post-Graduate Diploma is completed over a two year period. Students attend four theoretical papers; the Theory and Practice of Cognitive Behaviour Therapy, Cognitive Behaviour Therapy for Depression, The Anxiety Disorders and Chronic and Complex Problems. In the second year, a clinical practicum with supervised case-work over the course of one year is undertaken. All clinical work is video-taped and eight therapy sessions are scored for CT competency using the Cognitive Therapy Scale (Beck & Young, 1980). In addition students formally present, and document two case-studies. Groups A (2002) and B (2005) had completed the final theoretical paper CBT for complex and chronic problems, and Groups C (2002) and D (2004), were enrolled in the clinical practicum. The participants represented a wide range of mental health professionals including psychologists, psychotherapists, counsellors, social workers, nurses, psychiatric registrars, and general practitioners. Participants in each group were asked to complete the questionnaire anonymously. Participants in groups A and B were approached during their block course by the writer who was their course tutor, groups C and D were approached by the writer during supervision. In total, a group of 64 CT trainees returned the completed the questionnaire. The selection of the participants was influenced by their stage of training for comparative purposes. Groups A and B were at the end of the theoretical component of the post graduate diploma and groups C and D, at the tail end of their practicum experience.

Measures

The Therapist's Schema Questionnaire is a qualitative measure and consists of 46 assumptions representing 14 of the most common therapist schema namely; demanding standards, special superior person, rejection sensitive, abandonment, autonomy, control judgmental, persecution, need for approval, need to like others, withholding, helplessness, goal inhibition, excessive self sacrifice, emotional inhibition. Each schema was represented by 2 to 4 assumptions. Examples of assumptions are "I have to cure all my patients" and "I must always have the highest standards" which derive from the "demanding standards" schema; and "I should meet my patients needs" and "I sometimes think I would do almost anything to meet their needs," which underpin the "excessive self sacrifice " schema. At the time of writing there is no prior statistical information collected concerning the reliability or validity of this scale (R.L. Leahy - personal communication 19 April 2006). The participants were asked to think of a patient or group of patients with whom they were experiencing difficulties and rate the degree to which the assumption was true for them on a six-point rating scale, 1 = very untrue, 2 = somewhat untrue, 3 = slightly untrue, 4 = slightly true, 5 = somewhat true and 6 = very true. In addition, participants were cautioned not to give what they considered desirable answers, and the fact that there were no" right" or "wrong" answers was stressed. To be scored as significant, the participant needed to have rated one or more of the assumptions listed as "somewhat true" (5) or "very true" (6). Participants then received a total score out of 14 (the total number of common therapist schema listed).

Procedure

Each group was asked to complete the Therapist's Schema Questionnaire (Leahy, 2001). The completed questionnaires were anonymous and participants were given a choice whether or not to return the completed questionnaires to the writer. The majority of the participants returned their completed questionnaires, an exception was group D where two participants did not return their questionnaires but there was no follow up as this was an anonymous and voluntary exercise. The number of significant schema obtained by individual trainees was calculated. This resulted in each participant obtaining a score out of 14. In addition to individual scores, the frequency of significant therapist schema was calculated for each group. These frequencies were converted to percentages to facilitate comparison between the four groups as the groups were unequal in number.

Results

A very consistent pattern emerged across all four groups. Figure 1 shows a visual representation of the distribution of therapist schema identified across the four groups of participants. Visual inspection showed that except for one instance, there was no obvious difference between stage of training and the identification of specific schema.

In all four groups the most commonly identified therapist schema were; "demanding standards", "special superior person", and "excessive self sacrifice". The majority of participants, 75%-87%, identified with the "demanding standards" schema, signaling a somewhat obsessive, perfectionist, and controlling approach to therapy. The expectation that there is a "right" way to do things may lead to frustration and insecurity when therapy throws up the unexpected. This stance may indicate insecurity and a belief that if things deviate from the predicted structure the job is not being done properly and that, at worst, the trainee will be exposed as a "fraud".

A greater range, 62%-87%, between groups, was noted for the

identification of the "special superior person" schema, with a higher percentage of participants in the practicum group, 85%-87%, identifying with this schema. Those identifying with this schema see the therapy situation as an opportunity to achieve excellent results and have grandiose expectations for their own performance. There may be a tendency to idealize the patient, or conversely, devalue or distance oneself from a patient who does not improve or comply with treatment. The therapist may lack empathy.

Between 57% and 62% of participants identified with the assumptions associated with "excessive self sacrifice". Leahy suggests that therapists with this schema tend to overemphasize the importance of their relationships with patients. They may fear abandonment or feel guilty that they are better off than the patient. Self defeating behaviours, such as, going "overboard" to meet the needs of the patient may result from this schema. "Persecution" (6%-12%), the belief that patients are deliberately trying to undermine or harm the therapist, "goal inhibition" (0%-12%), a belief that the patient is blocking the therapist's goals, and "emotional inhibition" (0%-19%), the belief that the therapist has to repress all of his or her emotional responses were therapist schema consistently the least identified with.

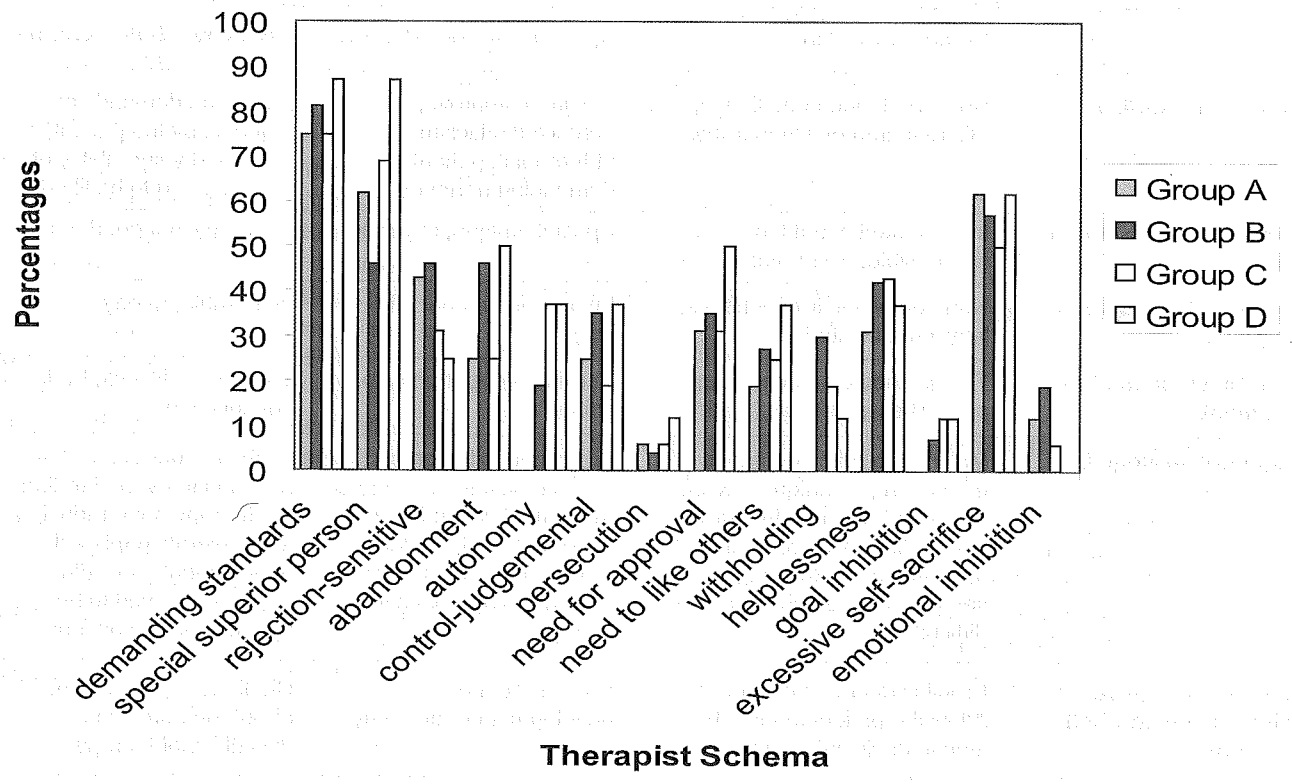
Discussion

General trends

The consistency in the pattern of schema identification across the four groups of participants is interesting, and it could be hypothesized that this may be related to their stage of development as cognitive therapists. Unfortunately there is, at the time of writing, no comparative data in the form of a group of more experienced therapists' responses to the Therapist Schema questionnaire, to support this hypothesis. In the personal observation of the writer, an experienced supervisor, "Demanding standards", indicating a need for certainty and a lack of tolerance for ambiguity, is characteristic of novice therapists. The emphasis on structure, and the strong evidence-based reputation of CT can encourage an expectation that there is always an "answer" and a "right way" to proceed. When confronted with patients who do not comply with treatment, fail to improve, or present with complex problems, the novice therapist can rapidly lose confidence and attribute difficulties to their own shortcoming, or lose faith in the model. Similarly, "excessive self sacrifice" is often observed in novice therapists who find it difficult to be appropriately assertive with patients, indeed this schema is also one most frequently observed in all therapists (Young Klosco & Weishaar, 2003). When this schema is present there may be a tendency to avoid techniques such as exposure for fear of upsetting the patient. The prominence of the "special superior" schema in the practicum groups appears to contradict the other two prominent schemas, with its connotations of entitlement and narcissism. The presence of this schema can be understood as one of the schema processes or coping styles which evolve in response to the threat of schema activation, proposed by Young, Klosko and Weishaar, 2003.

The processes; schema surrender, schema avoidance, and schema overcompensation develop as a response to "threat", and correspond broadly to the three basic responses to

Figure 1. Distribution of therapist schema in groups A, B, C, and D.



threat namely freeze, flight, or fight. The presence of the "special superior person" therapist schema can be seen as overcompensation in response to the "demanding standards" and "excessive self-sacrifice" schema, which have connotations of "not being good enough". The experience of the clinical practicum places the trainee in a position where their clinical work is intensely scrutinized in supervision through the evaluation of video-taped therapy sessions. Feeling special and superior may be, in some instances, a way of coping with the feelings of inferiority generated by this experience. It was heartening to observe that "persecution" was the therapist schema least identified as significant by the trainees. An attitude of mistrust and a mindset which tends to expect the worst from clients could be expected if this schema were present, and this attitude would seriously interfere with "unconditional positive regard", which is one of the most frequently cited attributes of a therapeutic relationship conducive to positive change in the client.

Training and supervision

In the training and supervision of cognitive therapists, the Therapist Schema questionnaire can be used in a number of different ways, firstly to increase the personal insight of the trainee, and secondly as a means to guide the relationship-driven interventions of the therapist. Some examples of these are; as a screening device, a mechanism to extract general themes which may be relevant to stage of training, as a way to orientate trainees to the existence and implications of some of their beliefs about patients and therapy, and most importantly, as interpersonal signals which can be fruitfully employed as an intervention. Each of these applications will be briefly discussed below.

A screening device

The questionnaire can be used in supervision as a mechanism to speed up the identification of potential problems which may emerge in the therapeutic relationship. For example if a trainee has a large number of significant schema this could signal that the trainee may be depressed or have low self esteem, be in an unsupported professional environment, or have significant interpersonal issues which may require individual personal therapy. Conversely a questionnaire indicating no significant schema might indicate that the trainee lacks personal insight or is somewhat complacent about their therapeutic skill. The responses to the questionnaire could highlight significant schema or combination of schema indicating serious interpersonal difficulties which need to be addressed.

General themes relevant to stage of training

The Therapist Schema Questionnaire is a fast, efficient, and engaging way to introduce trainees to the idea that they might have schema about their patients. It is easy to administer and score. The particular schema which are prominent in a group can be made part of general class discussions and in this way can de developmentally contextualized in terms of stage of training. For example the "demanding standards" schema can be usefully discussed in terms of unrealistic expectations which may be imposed on patients and the

Table 1. Cognitive profiles consistent with the therapists' schema; "demanding standards", "special superior person", and "excessive self-sacrifice"

	Demanding Standards	Special Superior Person	Excessive Self-sacrifice
Triggers in therapy	Homework non-compliance, failure to improve in therapy.	Failure to improve, perceived criticism of therapist, patient demanding or needy	Perceived demands or requests by the patient; perceived vulnerability of patient, need to be liked
Therapist beliefs about self	Incompetent, worthless, responsible, accountable	Special, unique, superior	Unworthy, not good enough
Therapist beliefs about the patient	Non-compliant, irresponsible, lazy, unmotivated	Inferior or superior (like me)	Vulnerable, needy
Therapist beliefs about treatment	Things should go according to plan. Therapy should "work".	This is an opportunity to shine.	Therapy is difficult, I will not succeed
Unhelpful strategies	Making too many demands on the patient, technique driven, over emphasis on structure, demanding, over-controlling and intolerant. Refusing to see patients perceived as too difficult.	When things become difficult, devalue and blame the patient, loose interest, become bored, neglect routine, empathy failure. Superficial approach to therapy.	Lack of boundaries resulting in overextending the therapy hour, reducing fees, tolerating missed appointments, avoiding issues perceived to be upsetting to the patient.
Healthy Alternative: Self-practice and Self-reflection	Practice decreasing control. Allow the patient to take the lead in decision making.	Encourage the development of empathy.	Challenge assumptions about the perceived difficulties of therapy.

importance of tolerating a degree of uncertainty and ambiguity as the process of psychotherapy unfolds.

Therapeutic implications of "therapist schema"

Once identified, prominent recurring therapist schema can be fruitfully conceptualized in supervision using the cognitive therapy model. An example of this is illustrated in Table 1, which illustrates the CT implications of the three most commonly identified therapist schema using the following headings: triggers, therapist beliefs about self, therapist beliefs about the patient, therapist beliefs about the course of treatment, unhelpful behavioural strategies which could result from the schema, and a healthy alternative to consider. This framework is based on the Therapeutic Beliefs System model proposed by Rudd and Joiner (1997).

Schema processes and maladaptive coping styles can be explained, and the trainee can use this knowledge to become more sensitized to his or her idiosyncratic triggers within the therapeutic situation, along with learning an alternative, more constructive response. Trainees can, within this context, be encouraged to practice CT techniques, helpful in altering strong assumptions and beliefs, on themselves. Self-reflection on this process will improve their knowledge of the application of CT interventions and increase their self-awareness (Bennett-Levy et al , 2001).

Conclusion

The contribution of the therapist and the impact of the therapeutic relationship are increasingly emphasized as important common factors in therapy outcome (Frank and Frank, 1993; Hubble, Duncan, and Miller, 1999, Wampold, 2001). When these factors are combined with the fact that therapists who are perceived by their patients to be non empathetic and punitive have been shown to have a negative effect on the course of therapy, the importance of training in this area is amplified (Bachelor and Horvath, 1999; Wampold, 2001.). Incorporating methods consistent with the CT model which encourage useful self-reflection in trainees is an important factor in improving therapeutic competency. This is supported by the results of a major longitudinal cross-sectional study tracking the professional development of 100 counselors and psychotherapists over a 15 year period which concluded that, "Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience" (Skovholt and Rønnestad , 2003).

The results of this study show that the Therapists' Schema questionnaire is a useful measure which can be employed in the training and supervision of cognitive therapists. It is a practical way to begin the identification of transference and counter transference processes in a manner conceptually consistent with the CT model.

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