Awareness: Facilitating the Therapeutic Dance along the Path of Growth and Change;

Evaluating the Psychometric Properties of a Therapist Schema Questionnaire

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Abstract

The importance of the therapeutic relationship and the therapist's contribution to the interpersonal processes, have been increasingly recognized as important factors in Cognitive Behavioural Therapy change and outcome. More specifically, the therapists' understanding and awareness of their own beliefs, assumptions and schema, and the potential effect that they can have on therapy, has been increasingly emphasized. Leahy's (2001) Therapist Schema Questionnaire (TSQ) is a potentially useful screening measure designed to identify Therapist Schema. No research has evaluated the psychometric properties of the TSQ. This study investigated the underlying factor structure and reliability of the TSQ in a therapist sample (N = 269). An exploratory factor analysis suggested a 7 factor structure and a 37 item scale that included 4 of the original 15 schema factors, as well as 3 additional factors, each containing a theoretically meaningful combination of original schema factors. The 3 most commonly identified Therapist Schemas revealed in the study were 'self-sacrifice', 'demanding standards', and 'sensitive/rejection'. The identified factors and the 37 item scale were found to have adequate to good internal consistency. Implications of these findings are discussed and recommendations are made for further research.

Keywords: Cognitive behavioural therapy, therapeutic relationship, schema, therapist schema, therapist self-awareness, self-practice, self-reflection, questionnaire validation.

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Overview

The quality of the therapeutic relationship is an important predictor of successful outcomes across all the dominant models of psychotherapy (Martin, Garske, & Davis, 2000; Horvath & Symonds, 1991; Wampold, 2001). The importance of the therapeutic relationship within Cognitive Behavioural Therapy (CBT) is being increasingly recognized as important in the process of change (Wampold, 2001; Skovholt, 2003; Gilbert & Leahy, 2007). More specifically, the growing awareness on clarifying the conceptualization of the therapists' contribution to the interpersonal process, to this inter relational dance, has become progressively emphasized in CBT (Liotti, 2007; Gilbert, 2007; Leahy, 2007; Persons, 2008).

Historically, the therapist and the therapeutic relationship has been less emphasised in CBT research (Garfield 1997; as cited in Skovholt, 2003). Up until quite recently it has received relatively little attention in the cognitive therapy literature and has been one of the perceived limitations of cognitive behavioural therapy (Clark, 1995). Over the last few decades, however, Cognitive-behavioural therapists have increasingly begun to recognize the therapeutic relationship as an important component in the process of change (Safran & Muran, 2000; Greenberg, 2007; Leahy, 2001; Gilbert & Irons, 2005; Leahy, 2005). As cognitive therapy has extended from its traditional origin of treatment protocols for depression and anxiety disorders to more complex treatments such as personality disorders, and with long-term and high-risk suicidal patients in particular (Beck et al., 1990; Layden, Newman, Freeman, & Morse, 1993), the emphasis on the importance of the therapeutic relationship and interpersonal processes within therapy has become

progressively more central (Skovholt, 2003). Working with more complex clients, such as those with personality disorders, brings a greater emphasis in working within the interpersonal arena as the clients main challenges are interpersonal in nature. Thus, working on interpersonal problems, many of which are reflected in the therapeutic relationship, is central when working with challenging clients.

Some CBT research has revealed the role that the therapist plays in either facilitating or hindering this interpersonal process within therapy (Leahy, 2001; Persons, 2008). This is seen in their capability to be aware of, ascertain, reflect upon, and make use of their own beliefs, assumptions, and schemas (underlying beliefs about self as therapist) that are triggered within the therapeutic relationship (Leahy, 2008). Firstly, the therapists' insight into his/herself can be enhanced by an awareness and identification of schemas, and secondly, this awareness can be useful in guiding the relationship-driven interventions of the therapist (Haarhoff, 2006). In addition to therapist self awareness and guiding the therapy interpersonal interventions, the importance of identifying Therapist Schema may also be beneficial and useful in the area of training and supervising of cognitive behavioural therapists, by enabling a clearer understanding of how these schemas may impact on therapy. Thus, the therapists' self awareness, self reflection and reflective practice(s) are seen as a primary means through which this understanding and proficiency can be acquired, and are an important contributor toward successful treatment outcomes in CBT (Safran & Segal, 1996; Rudd & Joiner, 1997; Leahy, 2001; Bennett-Levy, 2003).

The Therapists' Schema Questionnaire (TSQ: Leahy, 2001) is a potentially useful screening measure to identify Therapist Schema which could affect the therapeutic relationship (Leahy, 2001; Haarhoff, 2006). The validation of a measure

that potentially assesses and screens Therapists' Schema may have important implications in the personal development, training and in the supervision of cognitive behavioural therapists. At the time of writing, no research has evaluated the psychometric properties of the TSQ. It is, thus, the purpose of this research to determine the psychometric properties of the TSQ by investigating the underlying factor structure, along with its reliability among a group of therapists.

The thesis chapters and subsequent sections are organized as follows. Chapter 1 outlines the CBT model and presents the concept of the schema in CBT; covering schema theory including disorder specific schema, interpersonal schema and emotional schema, with particular reference to Therapist Schema. Chapter 2 gives an overview of the evolution of the therapeutic relationship in CBT from its early conceptualizations, the changes along the way, up to the more recent position distinguishing the therapeutic relationship as 'background' and as 'an intervention' (Persons, 2008).

Understanding the therapeutic relationship in CBT is covered in chapter 3. Influencing models and the importance of Therapist Schema awareness is discussed. Chapter 4 reviews the literature on ways to identify schema, unfolding the context for which the TSQ emerges. The TSQ is discussed, along with its potential utility in CBT and provides the foundation for the position of the present study. Chapter 4 concludes by presenting the current study, outlining the rationale and its purpose, along with its objectives and research questions.

The methodology is presented in chapter 5, chapter 6 documents the results, and chapter 7 offers a discussion of the overall findings and implications for CBT. Lastly, recommendations for further research are offered.

Chapter One: Cognitive Behavioural Therapy and the Concept of Schema

To provide context for the study this chapter outlines the CBT model. The concept of the schema in CBT is defined and the CBT theory of schema which includes disorder specific schema, interpersonal schemas and emotional schema, and most importantly the concept of 'Therapist Schema', is presented.

The Cognitive Behavioural Therapy Model

Cognitive behavioural therapy (CBT) was developed by Aaron T. Beck in the early 1960s as a structured, short-term, present-focused psychotherapy for depression. Since then, CBT has expanded and over the years has adapted to include protocols for all of the commonly seen clinical syndromes, including anxiety disorders, suicide, eating disorders, substance abuse, and complex disorders such as psychoses, schizophrenia and the personality disorders. In addition, CBT has been modified to be used beyond the clinical setting to other populations: prison inmates, school children, couples therapy, and group therapy, to name a few (Beck, 1995; Greenberger & Padesky, 1995).

The CBT model advocates that the way one thinks (the interpretation of a situation) influences one's emotions, behaviour, and physiological response, contributing to psychological disturbances. CBT treatment involves working alongside clients to identify, evaluate, and modify these thinking patterns, with the

aim to improve mood and problematic behaviour. The model prides itself as evidence- based psychological treatment which has evolved through a good connection between theory, experimental research studies and outcome research (Gilbert & Leahy, 2007).

The CBT model asserts that there are three levels of thought, namely- automatic thoughts, intermediate beliefs, and core beliefs/schemas. Automatic thoughts are on the surface level. These thoughts seem to pop up spontaneously, are not based on reflection or reasoning, are situation specific, and are a stream of quite rapid and brief thinking that coexist with a more manifest stream of thought (Beck, 1964). Intermediate beliefs are underlying assumptions, attitudes, or rules that guide our lives. These intermediate beliefs tend to manifest as "should" statements, such as "I should always be on time" and are conditional "if...then" beliefs, such as "If I am not on time, then I am disrespecting those waiting". They exist between the automatic thoughts and core beliefs.

Core beliefs, or schemas, are the most fundamental level of belief; they are global, rigid, absolute, dichotomous, and are often over generalized. Some examples of core beliefs could include "I am unlovable"; "Other people can't be trusted"; and "I am helpless". Further, these core beliefs/schemas have been described as cognitive structures, screens or filters, that process and code stimuli and hold specific content of the beliefs. Overall, they drive and influence both the development of the intermediate beliefs and the nature of the automatic thoughts. (Beck, 1995; Greenberger & Padesky, 1995).

An example, using the three levels of thought, could be a person trying to sleep the night before an exam having studied all of the prior day. They may have a thought "I just can't cope" (automatic thought); in addition they may believe "If I

haven't studied everything, then I'm bound to fail" (intermediate belief). Lastly they may hold a core belief/schema "I am a vulnerable, helpless person". Thus, these three levels of thought influence the person's sleep by contributing to symptoms of anxiety (problematic emotion) and insomnia (problematic behaviour).

In any situation, an underlying core beliefs/schema and intermediate belief could influence perception, which is expressed by situation-specific automatic thoughts and images. These thoughts, in turn, influence one's emotions and behaviours (Beck, 1995).

Understanding the interplay between the three levels of thought, and the mediating effect that they have on emotion, and behaviour, is foundational to the CBT model. On this basis, and, also in adherence with the focus of this study, the concept of the schema will be discussed next in more detail.

Schema in Cognitive Behavioural Therapy

There are many terms used to describe what a schema is in CBT; core beliefs, schemata, core structures, underlying set of beliefs, covert level, tacit knowledge, reality filters, cognitive template, and deep structures, to name but a few.

In taking a step back for a moment, it can be seen that the concept of ''schema'' was remnant in the work of Bartlett (1932 – 1958), Piaget (1926, 1936/1952) and also in the formulation by George Kelly (1955) of ''personal constructs'' (Beck, Freeman, Davis & Associates, 2004).

In CBT, Beck (1967) asserts the definition of schemas to depict cognitive structures. And, as previously mentioned, these structures are the 'core beliefs' level in the three levels of thought. He wrote that 'a schema is a structure for screening, coding, and evaluating the stimuli that impinge on the organism...On the

basis of the matrix of schemas, the individual is able to...categorize and interpret his experiences in a meaningful way' (p.283).

Another distinct definition, by Segal (1988) describes schemas as 'organized elements of past reactions and experience that form a relatively cohesive and persistent body of knowledge capable of guiding subsequent perception and appraisals' (p. 147). Also, Young (1994) proposed that a schema , or an early maladaptive schema (EMS) is defined as: "A broad, pervasive theme or pattern, comprised of memories, emotions, cognitions, and bodily sensation, regarding oneself and one's relationship to others, developed during childhood or adolescence, elaborated throughout one's lifetime" (p. 7).

Conditional versus unconditional schema.

In contrast to schemas being seen as solely unconditional in nature, both Beck et al. (1990) and Young, Klosko, and Weishaar (2003) acknowledge that schemas can be both unconditional and conditional. Theoretically, core beliefs and conditional beliefs both hold deeper cognitive structures than the surface automatic thoughts (Padesky, 1994). Beck et al., define schemas as "specific rules that govern information processing and behaviour" (p. 8), being both unconditional and conditional in nature. So, unconditional core beliefs such as "I'm no good" are distinguished with conditional intermediate beliefs such as "If people got close to me, they would discover the 'real me' and would reject me" (p. 43). Hence, both core and conditional beliefs are referred to as "schemas" in their text (Beck et al, 1990).

Young, Klosko, and Weishaar (2003), explicate that some schemas are conditional and others are unconditional, depending on when they were developed in the lifespan. Usually, those that are developed earliest in life are unconditional, at

the core, and are absolute. An example could be the "Abandonment" schema. In contrast, those that have developed later in life seem to be more conditional in nature and more feasible to change, such as the "Subjugation" schema. They could be viewed as '"secondary schemas" (p.23), and have often evolved to provide some release from the original unconditional schemas. (Young, Klosko, & Weishaar, 2003). An example of the perfectionist "unrelenting standards" schema in response to the "defectiveness" schema, with the original core belief "I am unlovable" could be, "If I can be perfect, then I will be lovable".

In summary, whether the definition of schema includes solely core beliefs, or a mix of core beliefs and intermediate beliefs, underlying assumptions, and rules; it can still be said that schemas are implicit, rigid, guiding themes or sets of deep cognitive patterns that exist to make sense of one's life experiences. The following section will attempt to review the theory of schema.

Schema Theory

It has been established that cognition is important in CBT as a maintaining factor in determining emotion and behaviour (Beck, 1967; Wells, 1997). Schema theory expands on this. In this section disorder specific schema, interpersonal schema and emotional schema are covered, with specific attention to Therapist Schema.

Disorder specific schema.

Beck (1967) postulated that the way that people with particular diagnoses think leads to the emotions and behaviours that are typical of the diagnosis. Disorder specific diagnoses have specific cognitions (thought processes) that underpin the specific presentation, and disorder specific models specify which

specific cognitions typically main the diagnosis presentation (Wells, 1997). For example, in Panic disorder, the disorder specific model explains that the client experiences the panic attack due to misinterpretations such as 'I'm going crazy' or 'I'm having a heart attack' of the anxious symptoms which result, for instance, in breathlessness or a pounding heart. And, that it is the specific cognitions (schema) that perpetuate the panic (Wells, 1997). Hence, schemas (core level of thought) play a central role in cognitive conceptualizations of a number of specific disorders. It is the specific cognition (thought, schema) that underpins the specific disorder, which leads in turn to the problematic emotion or behaviour.

According to Beck's (1967) cognitive behavioural theory of depression and anxiety, the schema construct is important in understanding depression and anxiety at the core beliefs level. Therefore, the content of depression disorder schemas tend to contain assumptions and beliefs that focus on loss, failure, and deprivation, while the content of anxiety schemas contain assumptions and beliefs pertaining to threat and danger and one's underestimated ability to cope (Beck, Emery, & Greenberg, 1985). For instance, in generalised anxiety disorder, schemas and beliefs about a general inability to cope may be seen. Further, Beck divided core beliefs into two domains; 'helpless' core beliefs and 'unlovable' core beliefs. 'Worthlessness' core beliefs were also added. These are in line with Beck's vulnerability domains of autonomy and sociotropy (Beck, Epstein, & Harrison, 1983). For example, an anxious client will tend to over emphasis threat or danger whilst underestimating their ability to cope. This is due to the notion that their main schema content is derived from helpless core beliefs and a 'vulnerability' schema. In addition, depressed clients tend to view themselves, others and the world in a negative light believing that they are unsupportive, deprived, not good enough and even bad.

These beliefs have their origins in the main disorder specific schema for depression being the 'unloveable' schema. Disorder specific schema has evolved from specific schema cognitive profiles for anxiety and depression (Beck, 1967) to include a range of many anxiety disorders. There are now disorder specific conceptualizations for each of the anxiety disorders namely Panic disorder, Agoraphobia, Health anxiety, Social phobia, Generalized Anxiety disorder, and Obsessive-compulsive disorder, and most other Axis I diagnoses in DSM IV (Well, 1997).

A few decades later Beck et al. (1990) extended his original model to include a disorder specific cognitive schema model for the personality disorders. For each of the eleven personality disorders identified in DSM lll, namely Avoidant, Dependent, Passive-Aggressive, Obsessive-compulsive, Paranoid, Antisocial, Borderline, Narcissistic, Histrionic, Schizoid, and Schizotypal, Beck identified specific schemas or cognitive profiles that they each map onto (Beck, Freeman, Davis, & Associates, 2004). For instance, the main schema for paranoid personality disorder is 'mistrust.' Their self view is that of being vulnerable to being treated wrongly by others. Their view of others is one of believing that the world around them is deceitful and devious. This in turn, enables them to hold core beliefs such as 'other people cannot be trusted'. Hence, their behaviour strategy is to always be on guard accompanied with a highly anxious or angry affect (Beck, Freeman, Davis, & Associates, 2004).

Beck et al (1990) further explains that these specific cognitive profiles include typical overdeveloped and underdeveloped behaviour strategies. Thus, clients with personality disorder traits tend to show certain behaviour patterns that are overdeveloped, and other behaviour patterns that are underdeveloped. For instance,

dependent personality traits may be characterized by a lot of clinging and help-seeking behaviour and a lack of self-sufficiency. Thus, the help- seeking and clinging behaviour has become overdeveloped and the self-sufficiency underdeveloped (Beck et al., 1990).

So far, the schema theory has focused on Beck's schema model of disorder specific schema. Young (1994) extended Beck's original model of schema theory to address the needs of clients with long-standing characterological disorders. Young's schema model (Young, 1994) was influenced by the constructivist perspective, whereby individuals throughout their lives are understood to continually and actively structure and restructure experiences, construct their personal realities, and create their own representational models of the self, others, and the world (Mahoney, 1995). Young hypothesized that some of these schemas, especially those that evolved from childhood toxic experiences and other traumatic experiences beyond parenting, might be the core of personality disorders, milder characterological problems, and many chronic Axis I disorders. Examples of these early experiences could be deprivation of needs from significant others where stability, understanding or love is lacking, or, traumatization or victimization. In addition, being spoilt, indulged, or overprotected are further examples of childhood experiences that are often at the core of personality disorders (Young, Klosko, & Weishaar, 2003).

Central to Young's (1994) theory is the concept of early maladaptive schema (EMS). Young asserts that these EMS's are the product of the interplay between these early dysfunctional life experiences, mentioned above, and the individual's emotional temperament. Thus, during childhood, the EMS (also known as a core belief) is a means for the child to make sense of and manage the environment, but in

later years anxiety and/or depression can result when the EMS is triggered by circumstances related to that specific schema. So, at the cognitive level, the schema is maintained and reinforced over time by magnifying information that confirms the schema, and negating or minimizing information that is inconsistent with the schema. Because they often develop early in life, they become central to people's self-concept and also their view of the environment. Hence, they become very comfortable and familiar, and, very resistant to change (Young, 1994; McGinn & Young, 1996; Young, Klosko, & Weishaar, 2003).

Originally, Young (1990) proposed sixteen schemas based on clinical experiences. Since then, they have evolved to eighteen schemas (Young, Klosko, & Weishaar, 2003). They include thirteen unconditional schemas and five conditional schemas. The thirteen unconditional schemas are Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, Dependence/Incompetence, Vulnerability to Harm/Illness, Enmeshment, Defectiveness, Social Isolation, Dependence/incompetence, Vulnerability to Harm or Illness, Enmeshment/Undeveloped Self, Failure, Negativity/Pessimism, Punitiveness, Entitlement/Grandiosity, and Insufficient Self-Control/Self-Discipline. The remaining five conditional schemas are Subjugation, Self-sacrifice, Approval-Seeking/Recognition-Seeking, Emotional Inhibition, Unrelenting Standards/Hyper-criticalness (see Appendix G).

These schemas are organized under five domains/headings. They are Disconnection and Rejection, Impaired Autonomy and Performance, Impaired Limits, Other-Directedness, and Over vigilance and Inhibition. And, each of the five domains is believed to interfere with a core need in childhood (Young, 1990). For example, the 'Self-sacrifice' schema falls under the 'Other-Directedness'

domain along with the ‘Subjugation, Approval-Seeking/Recognition-Seeking’ schemas. Within this domain there is excessive focus on others desires and needs at the cost of one’s own and the typical family origin is one based on conditional acceptance. Many times, the parents’ desires are the priority over the unique needs and feelings of the child (Young, 1994) (see Appendix G for a complete transcript of early maladaptive schemas with associated schema domains).

Each thought, emotion, behaviour, and life situation can be seen to fall into two categories with relation to schemas. They can reinforce and perpetuate the schema, or on the other hand, they can be seen to heal the schema, hence diminishing it. Young’s (1994) schema theory identifies that schemas are perpetuated through three schema coping styles and processes. These three processes are schema surrender, schema avoidance, and schema over compensation. Schema surrender refers to the individual surrendering and accommodating the schema, without fighting or avoiding it. For example, a person with the self-sacrifice schema may always give to others and never have any expectations of receiving anything back. The second coping response, schema avoidance, is when the individual will live a life, without an awareness of the schema, avoiding it completely. An example could be seen again with a person who has the self-sacrifice schema, in which they avoid situations involving receiving. They may avoid ever celebrating their birthday to avoid receiving attention or love from others. In the third coping style, Schema overcompensation entails the individual overcompensating and doing the exact opposite to what one would expect. For example, an individual with the unrelenting/demanding standards schema, may have been a perfectionist as a child, but as an adult fights the schema by not caring about

standards at all and doing things carelessly. All of these three coping styles serve to maintain and perpetuate the schema (Young, Klosko, & Weishaar, 2003).

Interpersonal schema and emotional schema.

Safran (1990) contributed to schema theory by expanding the schema understanding from the individual, personal, 'self-schema' to include the concept of interpersonal schema. Interpersonal schemas are the schematic representations of self and other interactions. These relational schemas are developed over time and are based on one's interpersonal life experiences, thus, have a strong influence on how one predicts and maintains their current interpersonal relatedness (Safran, 1990; Katzow & Safran, 2007).

In addition, schema theory has been extended to accommodate 'emotional schemas'. These are schemas which influence the way emotions are expressed (Leahy, 2007). For example the view of emotions being a sign that one is 'out of control', 'crazy' and therefore cannot be expressed. Hence, these emotional philosophies are often reflected in the emotional schemas of the client ("my emotions are shameful") or therapist ("emotions get in the way of the therapy goals and waste time"). Thus, it can be seen that both interpersonal schema and emotional schema have an effect on the therapeutic relationship and client outcome, in addition with therapist schema. Therapists as well as clients have schema which could be categorized under both interpersonal schema and emotional schema. Therapist schema will now be discussed.

Therapist Schema.

In the previous section the main focus of schema theory was discussed with respect to disorder specific schema as seen in the client population. This section, in turn, looks at the schema of the therapist. Therapist Schema entails the underlying

beliefs that the therapist holds about themselves as a therapist (Leahy, 2001; Bennett-Levy & Thwaites, 2007). Therapist Schema is distinguished from client schema in a number of ways.

In Schema theory it has been argued that EMS's distort information regarding the self and environment and have a dysfunctional overtone. However, according to Young and Klosko (1993), these schemas are also present in normal populations but become exaggerated and extreme in symptomatic individuals. So, in a general sense, a schema can be seen as any broad organizing principle for making sense of one's life experience. By this broad definition, Young, Klosko, and Weishaar (2003) assert that "a schema can be positive or negative, adaptive or maladaptive; schemas can be formed in childhood or later in life" (pg 7). Therefore therapists as part of the human race also have these types of schema. The Therapists' Schema is similar to EMS's, but is less enveloping and severe. And, in this context, the Therapists' Schema is not generally an indication of pathology, but rather, it is more conditional in nature, being activated and triggered in the therapy setting, through transference/ counter-transference processes, and by other triggers (Rudd & Joiner, 1997; Leahy, 2001; Katzow & Safran, 2007). For instance, a Therapist Schema may be triggered whilst working with a specific client group. For example, they may find it difficult when working with a client who has a history of paedophilia assaults. Whilst working with this individual the judgemental schema is triggered bringing to the surface beliefs such as 'some people are basically bad people', or 'people should be punished if they do wrong things' (Leahy, 2001). Having these beliefs triggered could interfere with the therapeutic relationship and client outcomes, especially if they are outside of the therapist's awareness and are not identified and/or modified.

Rudd and Joiner (1997) describe therapist beliefs/schemas to be similar to the client's beliefs in shifting along a continuum from a potential victimizer, to collaborator/partner, to saviour in their Therapeutic Belief System (Rudd & Joiner, 1997). The Therapeutic Belief System (Rudd & Joiner, 1997) is a framework for understanding the beliefs within the therapeutic relationship in CBT. These schemas are addressed on two levels: the readily accessible 'active' (automatic thoughts/intermediate beliefs), and the core/ 'tacit' (implicit, unspoken). The ideal is for the therapist to be 'a collaborator' in which the therapist would hold the belief 'If I work with this patient, they'll probably improve'. But they further caution that unhelpful schema could be triggered, such as the therapist holding the helpless victim beliefs about them self as a therapist 'If I don't do more for this patient, they'll get worse' (Rudd & Joiner, 1997). Rudd and Joiner continue to explain that if the active and tacit levels are both diagrammed by the therapist, then this could reveal that the therapist schema could be operating in conflict. For example, a more challenging client who may be pushing the therapist's buttons may trigger the 'incompetence' or 'inadequate' Therapist Schema (Leahy, 2001). The therapist could have an active 'hope' belief in a client, but then at the same time have a tacit (unspoken, core) response of 'withdrawal'. The therapist's behaviour could result in the re-scheduling, the postponement or even the eventual termination of the therapeutic intervention as a result of implicit, unstated internal conflicts stemming from the therapists interpersonal conflict.

Bennett-Levy and Thwaites (2007) suggest a distinction between two types of Therapist Schema; the personal (self schema) and the professional (self-as- therapist schema). The therapist's self schema is described as 'the person of the therapist' (Gilbert, Hughs, & Dryden, 1989; as cited in Bennett-Levy & Thwaites, 2007,

p.259) and holds the therapist's beliefs, skills, values, and experiences. This is no different from the schema theory that has been discussed to this point. Further, the therapist self schema is developed before becoming a therapist and can have an influence on one's therapeutic interpersonal skills and the therapeutic relationship. In addition to the therapist's self schema, the therapist's 'self-as-therapist schema', is the new identity which the therapist embraces, whilst training to be a therapist. New beliefs, attitudes, assumptions and behaviours are developed about the self, clients, and the therapy process, whilst, at the same time, incorporating some that already exist. For instance, a therapist may already contain 'compassion for people in distress' and may not need to develop this (Dryden & Sperling, 1989; as cited in Bennett-Levy & Thwaites, 2007).

There are many things which influence Therapist Schema including personal upbringing, self schema, personal therapy, peer group, therapist professional training, therapist professional experience, self-reflection, supervision, and the therapeutic relationship, to name a few (Haarhoff, 2006; Leahy, 2001; Bennett-Levy & Thwaites, 2007; Rudd & Joiner, 1997).

Based on clinical experience and observation, Leahy (2001) has proposed fifteen common Therapist Schemas: demanding standards, special superior person, rejection sensitive, abandonment, autonomy, control, judgmental, persecution, need for approval, need to like others, withholding, helplessness, goal inhibition, self-sacrifice, and emotional inhibition (see Appendix F). Six of these common Therapist Schemas; demanding standards, special superior person, abandonment, autonomy, need for approval, and excessive self-sacrifice, are described in more detail by Leahy (2001).

'Demanding standards' describes the perfectionist or obsessive-compulsive therapist who demands a lot from their clients. Further, therapists with 'abandonment' concerns may find it difficult to confront their clients on important issues for fear that the client may leave therapy prematurely. Another common Therapist Schema is seen with the narcissistic therapist who has the 'special superior person' schema. They may view therapy as an opportunity to show off their talents, and if the client is not supporting this idealization, then the therapist can become bored with the client and lose interest or devalue them. Also, the 'pleasing' therapists have the 'need for approval' Therapist Schema, and are driven to always make sure the client feels good. Any sign of anything less than this is a sign of personal failure. Another common Therapist Schema is the 'autonomy' schema, where the therapist has an overdeveloped sense of autonomy and any extra demands from the client are a point of reaction and conflict on behalf of the therapist. In addition, Leahy describes the 'excessive self-sacrifice' Therapist Schema. Here the therapist places the client's needs before one's own, struggles with being assertive, and may receive a sense of value by being needed by the client (Leahy, 2001).

Importance of schema

The importance of understanding schemas in CBT and within the therapeutic relationship has been stressed in the CBT literature (Beck et al., 1990; Young, 1990; Beck, 1996; Leahy, 2001). The concept of schema in schema theory has been reviewed throughout the literature to include individual schema, Therapist Schema (both self-schema and self-as –therapist schema), interpersonal schema and emotional schema, all of which may have an effect on the therapeutic relationship and client outcome.

The importance of Therapist Schema and the effect it may have on the therapeutic relationship is the core of this thesis and research. Of interest, is the way therapist's beliefs and schema may unknowingly influence therapy if they are out of the therapist's awareness (Persons, 1989). Thus, it is important for the therapist to develop an awareness and understanding of their schema, and be able to identify and address any interfering effects, especially when working with complex clients, whose main issues are within the interpersonal arena (Leahy, 2001; Haarhoff, 2008). The importance of Therapist Schema awareness will be discussed in more detail in chapter 3, (see chapter 3, p. 49).

In summary, this chapter has described the CBT model, focussing on the concept of schema in CBT. Schema theory has evolved over time from a general theory to a more specific cognitive schema model (Beck, 1967; Beck et al., 1990; Young, 1990; Wells, 1997), including interpersonal and emotional schemas (Safran, 1990). In addition, schema theory has evolved to not only pertain to client schema but also has extended to include the importance of Therapist Schema (Leahy, 2001). Chapter 2 will give an overview of the evolution of the therapeutic relationship in CBT. This overview provides the platform highlighting the significance of why identifying and working with the Therapist Schema within the therapeutic relationship is important. This then contributes to the rationale behind validating a measure to help identify therapist schema, and is thus the focus of this current research.

Chapter Two: The Evolution of the Therapeutic Relationship in Cognitive Behavioural Therapy

There are many terms that have been used to describe the therapeutic relationship. The working relationship, the therapeutic bond, alliance, and therapeutic alliance, are some of these. In short, the therapeutic relationship entails the totality of the interpersonal bond between the client and therapist, the agreement of goals and tasks, and their relationship history that they each bring to the relationship. The therapeutic relationship has been considered important to the therapeutic process in all the dominant models of psychotherapy (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Wampold, 2001; Gilbert & Leahy, 2007).

In order to contextualise the utility of Therapist Schema this chapter gives an overview of the evolution of the therapeutic relationship in CBT; describing early conceptualisations, development and evolution through various changes over the past four decades, and most importantly clarifying the more recent conceptualization, which distinguishes the therapeutic relationship as 'background' and as an 'intervention'(Persons, 2008).

Early Conceptualizations

The position of establishing a strong collaborative relationship between the client and the therapist has always been a guiding principle in the CBT tradition,

although, historically it was perceived as a less important variable in the change process (Safran, 1990).

According to CBT guiding principles, the therapist's task was to create a good working relationship, which would in turn serve as a basis for technical interventions (Persons, 1989). In this working relationship, therapists were to be genuinely warm, empathetic, open, trusting, and positive whilst developing therapeutic goals and homework assignments in a collaborative manner, while also giving on-going feedback and rationales to the client; all of which were perceived to enhance this working relationship (Beck, 1995). Hence, the emphasis was on the importance of being 'collaborative' and the therapist's active role of 'establishing a collaborative therapy relationship'. Beck and colleagues (1979) called this 'collaborative empiricism'.

Thus, the therapeutic relationship in CBT was recognized as a necessary but not sufficient condition for change (Beck, 1979). Conceived in this way, the focus was on the technical interventions of therapy. 'Micro skills', for example, questions that may encourage the client to share, or non verbal communications that may help the client feel safe, were overlooked or assumed, or barely touched on in some treatment manuals (Gilbert & Leahy, 2007). Rudd and Joiner (1997) reveal how in the original text of cognitive therapy for depression, Beck, Rush, Shaw, and Emery (1979) devoted only a few pages to the topic of the therapeutic relationship (Rudd & Joiner, 1997). Hence, CBT has been criticized by clinicians outside the CBT tradition for not paying enough attention to the complexities of the therapeutic relationship (Clark, 1995; Gilbert & Leahy, 2007), resulting in a somewhat distorted perception of CBT as mechanical and cold.

Further, traditional CBT perceived the therapeutic relationship as a 'nonspecific' factor, for instance, a factor that was common to all types of psychotherapy and not necessarily responsible for change, which was distinguished from being a 'specific' factor. 'Specific factors' were specific intervention techniques, applied in a particular type of psychotherapy, which were seen as being those primarily responsible for change (Katzow & Safran, 2007). Wilson (1984) suggested that CBT therapists would learn these nonspecific therapy skills naturally, from their own social learning life experiences and in clinical supervision (Wilson, 1984; as cited in Safran & Segal, 1996). In other words, these specific techniques, protocols, and processes were the focus, due to the belief that they were sufficient and enough to facilitate change (Leahy, 2008).

The traditional account of the therapeutic relationship in CBT rejected the psychodynamic concepts of transference, countertransference, and resistance. For example, client resistance was conceptualized as 'treatment non compliance' (Safran & Segal, 1996). This non compliance was historically viewed to be due to factors involving the client (such as failure to do homework), therapist (such as misapplication of techniques or incomplete conceptualization), or therapeutic relationship factors (such as a poor attributional match) (Blackburn & Twaddle, 1996).

According to this view the 'non compliance' needed to be identified, and worked on before the current presenting issues could be addressed in treatment. For instance, the therapist would address the issue of non compliance by attempting to provide an adequate rationale for treatment and homework tasks, thus enhancing positive client expectations of therapy. In addition, a collaborative approach to the homework tasks was also taken (Safran & Segal,

1996). So, overcoming 'resistance' in therapy was done by continuing to apply standard CBT techniques such as 'refining the conceptualization' rather than directly discussing the alliance. For example, depending on the identified problem, the therapist may consider redoing the conceptualization of the client in writing and then collaboratively addressing it with the client. Hence, they undermined the idea that working with the non compliance in itself is central to a successful outcome. (Goldfried, 1982; Meichenbaum & Gilmore, 1982; as cited in Safran & Segal, 1996). The tendency to undermine the non-compliance was because the reliance was placed on the CBT techniques to be sufficient when carrying out standard short-term CBT for instance, with Axis I clients. Thus, the emphasis, in contrast, was on minimizing this occurrence in therapy. These original techniques for managing client resistance in the therapeutic relationship are still useful in CBT today. Hence, for the majority of the time the therapeutic relationship is sufficient as background as standard CBT therapy for Axis I clients is focused on the usual disorder specific presenting problems such as depression and anxiety symptoms, rather than problems within the interpersonal arena, such is seen with Axis II clients.

As a final note, Clark (1995), points out that historically the role of the therapeutic relationship was not clearly defined. This lack of clarification has been a perceived limitation of standard CBT (Clark, 1995). In addition, there was only a limited conceptual framework for working within the therapeutic relationship.

Changes over the Past Four Decades

The emergent influences in the literature have facilitated the evolution of the conceptualization of the therapeutic relationship in CBT: The concept of the three components bonds, tasks and goals, the constructivist/social learning perspectives, the cognitive-interpersonal perspectives, with a growth of working with more complex disorders such as personality disorders, and empirical findings bringing to light new therapist-client processes, for instance, attachment processes (Liotti, 2007) and schematic processes (Leahy, 2001). These influences are discussed below.

Bonds, tasks, and goals.

Firstly, this evolution was influenced by the early developments of Greenson (1965) who developed the idea that the relationship is central for change and distinguished between the working alliance (task focused) and the therapeutic relationship which is bond focused. Further, Bordin (1979, 1994) contributed to these changes with his reconceptualization of the therapeutic relationship in transtheoretical terms. Bordin authored a major contribution to the alliance literature by emphasizing therapist-client interactions with his identification of three independent components: 1) development of therapist-client bond (i.e., trust and attachment); 2) agreement on tasks (i.e., assignments and technical specifications of the treatment; and 3) agreement on goals (i.e., the desired end results). Later, Safran and Muran (2000) extended this approach to see the alliance as a process of ongoing negotiation and the resolving of ruptures as an important part of treatment (Katzow & Safran, 2007).

Other various theorists started to challenge the traditional view of the therapeutic relationship. Among these theorists were Arnkoff (1981) who saw the therapeutic relationship as a means of understanding the client's wider

relationships (Arnkoff, 1981; as cited in Blackburn & Twaddle, 1996). Also, Jacobson (1989) explained how the therapeutic relationship itself could produce change in depressive clients (Jacobson, 1989; as cited in Blackburn & Twaddle, 1996). In addition, Guidano and Liotti (1983) and Guidano (1987) argued how the therapeutic relationship provided the necessary context for developmental history to unfold (Guidano & Liotti, 1983; Guidano, 1987; as cited in Blackburn & Twaddle, 1996). Similarly, Padesky (1993) emphasized the importance of the therapist listening 'beyond' the Socratic questioning to the idiosyncratic detail, metaphors, and emotional responses. And that this listening 'beyond' could facilitate in itself the therapeutic processes in the therapeutic relationship.

Constructivist/social learning perspective.

The Social learning perspective with its social and developmental psychological principles such as persuasion, expectancy, attitude change, and interpersonal attraction, influenced the view that the therapeutic relationship was of value (Bandura 1969; Staats 1970; Ullman & Krasner, 1965; as cited in Safran & Segal, 1996). Along with the social learning perspective, Social Constructivism also added the idea that the individual actively participates in the construction of their reality. This perspective asserts that our understanding of the world evolves through relationship and is constructed through our interactions with social and historical contexts (Gergen, 1985; Osbeck, 1993; Shotter, 1992). This constructivist view placed a different emphasis on resistance, a view emphasizing the need to directly address and deal with the resistance in an active, joint, co- constructive way (Dowd, 2002; Mahoney, 1995; Neimeyer, 1986, as cited in Blackburn & Twaddle; Liotti, 1987, as cited in Blackburn & Twaddle, 1996). For example, the therapist and client talking over the problem moment

areas together when they arise in the therapeutic relationship, and reconceptualising these interpersonal impasses together (Katzow & Safran, 2007).

Cognitive- interpersonal perspectives.

Another main influence on the changing emphasis on the therapist-client relationship within CBT was the development of the interpersonally based perspectives. Safran (1990) developed theories with the interpersonal dimension in CBT and asserted that the therapeutic relationship is the main channel in which core dysfunctional interpersonal schemata is revealed (Safran, 1990; Safran & Segal, 1990). The focus is on the interaction between the client and the therapist and how this often reflects the client's dysfunctional interpersonal schemata. Hence, this influenced the view of the therapeutic relationship to be seen as a 'training ground', in which new interpersonal patterns could be developed (Blackburn & Twaddle, 1996).

The interpersonal influence offered with it the extension in CBT into the line of working with more complex disorders such as personality disorders. More effort started to be made to address the therapeutic relationship with the addition of CBT treatment approaches for more complex disorders such as personality disorders (Beck et al, 1990; Layden, Newman, Freeman, & Morse, 1993; Linehan, 1993; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). The traditional disorder specific CBT conceptual model 'treatment packages' didn't seem to fit so easily with these complex presentations with their cocktail of symptomatology, and co morbidity, coupled with interpersonal challenges (Haarhoff, 2008). These treatments revealed the need for longer treatment and an increasing recognition of the therapeutic relationship as an important component for successful outcomes (Rudd & Joiner, 1997). This was due to the more

characterological nature of personality disorders, the conceptualization that interpersonal challenges are central to this client group, and would be reflected in the inter relations between the therapist and client. Therefore the therapeutic relationship provided many opportunities to work on these problematic interpersonal areas.

This attention to relationship issues marks a distinct point of departure for CBT researchers, as the majority of the literature has historically focused on the efficacy of specific technical interventions, with less emphasis on the therapeutic relationship. Hence, a shift towards more individual conceptualization/formulation processes (Persons, 2008) rather than 'treatment packages', including more interpersonal and emotional dynamics (Greenberg, 2007) has become increasingly evident.

This shift includes emphasizing the importance of focusing on therapeutic impasses (Katzow & Safran, 2007), and joining the resistance of clients (Leahy, 2001). For instance, Young, Klosko, and Weishaar (2003) emphasize 'empathic confrontation' at impasse moments, in which the therapist validates and empathizes with the clients' reactions towards them in the relationship supporting them to challenge and work with some of these beliefs collaboratively within the therapeutic relationship (Katzow & Safran, 2007). Further, Leahy (2008) stresses, CBT may be 'uniquely qualified' (p. 774) to both use, and to help in the resolution of such conflicts, resistance, and impasses in the therapeutic relationship. For instance, providing strategies of intervention, consistent with the CBT model, and are effective in utilizing the therapeutic relationship as an intervention itself to help resolve the impasses (Leahy, 2008).

Empirical findings.

In addition, empirical findings provided evidence that the therapeutic relationship affects outcome. Persons and Burns (1985), study results showed that both the traditional technical interventions employed and relationship factors had an effect on mood change during the CBT sessions (Persons, 1989). Also, Wampold (2001) presented two meta-analytic studies to examine the alliance-outcome relationship. In the first study, Horvath and Symonds (1991) revealed evidence for a strong alliance-outcome relationship and, in the second study Martin, Garkse and Davis (2000) confirmed the alliance-outcome relationship. Wampold (2001) argued that the core of therapy is embodied in the therapist and that the 'person of the therapist is a critical factor in the success of therapy' (Wampold, 2001).

Further, recent research, was bringing to light new processes and issues important to therapeutic relationships – the importance of non-conscious processing, emotional awareness and socialization, attachment processes, shame and compassion, mindfulness, schematic processes, and interpersonal strategies. Each of these areas has had an influence on the increasing emphasis placed on the therapeutic relationship in CBT and how to integrate such insights into the therapeutic relationship. (Katzow & Safran, 2007).

Distinguished as the 'Background', and as an 'Intervention'

The evolution of the therapeutic relationship in CBT can be seen over the last four decades from its early conceptualization of the relationship viewed as the background 'necessary but not sufficient' for change to incorporate the more recent consensus of the relationship viewed as an intervention in itself. In this

combined view of the therapeutic relationship, the therapist uses good interpersonal skills and other skills to establish and maintain the therapeutic relationship in order to facilitate and provide a background, a foundation whereby the technical interventions of therapy can be carried out, including using the client-therapist interactions and behaviours as opportunities to facilitate assessment, conceptualization and intervention (Persons, 2008). Each separate view will be reviewed and then the combined view of the Case formulation approach to the therapeutic relationship in CBT will be discussed.

In chapter 2 (see chapter 2, p.20) the traditional CBT view explained that the therapeutic relationship was seen as a background to support therapy, 'necessary but not sufficient' for good outcomes (Beck, 1979). The main focus of the therapeutic relationship was to build a collaborative working relationship which would be a supportive platform to enable the application of the technical skills and interventions. Therefore, the therapeutic relationship was seen as a 'nonspecific' factor, not as an intervention tool in itself, but rather, as something used in the background that enabled the interventions to take place. Thus, emerged the notion, that, good outcomes would result when the client and therapist carried out the therapy techniques within the background context of a healthy therapeutic relationship.

Influences over the last four decades include the concept of the therapeutic alliance consisting of three components: the bond and an agreement of tasks and goals (Bordin, 1979). Also, social learning perspectives and empirical findings were influences seen in the evolution of the therapeutic relationship in CBT. In addition, the increasing need to address complex client problems, such as personality disordered clients whose problems were most often inter relational in

nature, also influenced the view of the role of the therapeutic relationship in CBT. Thus, the traditional view was in some instances seen as inadequate, as in when the clients' problems made it difficult for the therapist to establish a good working relationship utilising such techniques as warmth, trust, and respect, to name but a few. Therefore the view of extending the therapeutic relationship to incorporate being an intervention in itself was developed (Persons, 2008).

The therapeutic relationship can be seen as an assessment and intervention tool in itself. According to this view, the relationship is seen as treatment in itself, and as Person (2008) explains, this is the view of 'relationship – as – treatment' (Persons, 2008). This view is based on the idea that many of the client's behaviours and interactions with the therapist whilst in therapy are mirrors of behaviours and inter relational interactions that are also seen outside of therapy in the client's own world. Further, it reflects the interpersonal schemas, and earlier attachment problems of both the therapist and the client (Leahy, 2008). It considers what the client and the therapist both bring to the relationship through their experiences from their past relationships (Leahy, 2001). These experiences influence the nature of the relationship dynamics that are being formed (Holmes, 1996; Mace & Margison, 1997; as cited in Hardy, Cahill & Barkham, 2007). Thus, the therapist views the client-therapist interactions in therapy as samples of client behaviours outside therapy. In addition, the behaviours and interactions are often part of the client's presenting problems and the reason why they have come to therapy (Persons, 2008). The therapist-client interpersonal interactions provide a very rich and valuable area for therapeutic intervention.

Therapies guided by this view of relationship – as – treatment view include functional analytic psychotherapy (FAP) (Kohlenberg & Tsai, 1991) and

cognitive behavioural analysis system of psychotherapy (CBASP) (McCullough, 2000). In this view, problems within the therapeutic relationship and problem behaviour are not viewed as obstacles, but rather as opportunities to conceptualize and to intervene. In addition, dialectic behavioural therapy (DBT) (Linehan, 1993) uses similar ideas, emphasizing the importance of first developing a 'strong positive relationship' and then using the relationship to bargain and negotiate behaviour change with the client, in relation to their difficult and challenging behaviours (Linehan, 1993).

Empirical support for the 'relationship-as-treatment' view, whereby the therapeutic relationship contributes more to therapy outcome than the technical interventions, is seen in two reviews: one by Lambert and Barley (2002) and another by Wampold (2001). Thus, as Wampold (2001) explains, the relationship is the main variable, that accounts for more than all the other ingredients put together in successful outcome (Wampold, 2001).

So far, the discussion has focused on two views of the therapeutic relationship in CBT: The traditional background view and the view of the relationship as an intervention in itself. In addition, the case formulation approach (Persons, 2008) to the therapeutic relationship in CBT provides a combined view, and this is now discussed.

The Case formulation-driven approach (Persons, 2008) to the therapeutic relationship in CBT relies on both views; the therapeutic relationship as background and the therapeutic relationship as an intervention tool in itself. The client and therapist build and maintain a good, strong, collaborative working relationship as a background toward supportive intervention. At the same time this approach draws on the case conceptualization firstly to assess and facilitate

both the therapists' and the clients' understanding and conceptualization of their interpersonal dynamics and, secondly, to inform and guide the therapy relational interventions using the therapeutic relationship as the intervention tool. For instance, anger, dependency, and over compliance expressed or observed in sessions may give clues as to behaviour outside of the therapy. And these interactions between the client and therapist can be opportunities to aid assessment, and to add to the case conceptualization. Hence, the therapeutic relationship is seen as a powerful assessment tool and as a route to understanding (Persons, 1989).

In addition, the relationship can be used as an active tool for promoting change and aids in intervention (Persons, 2008). Goldfried and Davila (2005) explain that the therapist can use both the technical and 'in vivo' interpersonal interactions to facilitate the change process. And Persons (2008) further explains how therapy happens on two channels, through the channel of technical intervention and also through the interpersonal interactions. The channel of interpersonal interactions can be extremely effective because it is 'in vivo' and usually highly emotionally charged (Goldfried, 1985, as cited in Persons, 1989; Safran & Greenberg, 1986, as cited in Persons, 1989).

An example of the two channels of intervention could be seen with a passive client, who is trying to manage feelings of helplessness and anxiety. The case conceptualisation helps the therapist decide whether the client's helplessness stems from their beliefs or not, and then the use of the technical intervention of a thought record could aid the client in identifying, addressing and providing more balanced thoughts when in anxious situations. This in turn could guide how accommodating or helpful the therapist should be with the client with inter

relational interactions. More specifically, the case conceptualization informs the therapy interventions by the therapist constantly weighing up how much is the therapists part in the session role plays and 'in vivo' tasks and how much could be give to the client to carry out to ensure that the therapy is still beneficial, and not feeding into the possible learned helplessness. The client can then model and carry out these inter relational interactions learned with the therapist in the client's own world. Thus, working with the non compliance in itself, with the foundational support of a well established therapeutic relationship in place, is central to successful outcome.

On a final note, the therapeutic relationship has evolved to be seen as a 'co creation', an 'ongoing process' (Leahy, 2008) of 'ongoing negotiation' (Safran & Muran, 2000). This continual negotiation depends on the ability of both parties to be able to reach the right fit of all the expectations, beliefs and needs that they both bring to the relationship. Therefore, technique and the interpersonal context and the therapeutic relationship as an intervention in itself all go hand in hand, and any intervention's effect depends on what it means to each of them, including the therapist. This understanding needs to guide the therapist. And, whilst this will happen naturally most of the time in the relationship (for example when things are going well and with specific disorder clients) the therapist also needs to concentrate more on this 'negotiation' when things are *not* going so well, for instance, when there is an obvious disruption in the therapeutic relationship when working with clients in the interpersonal arena. A specific example of this could be the common challenge of negotiating the needs of self and others. Thus, with clients facing this challenge, the 'tension' moments in the relationship can

provide an opportunity for the therapist and the client to explore a probable 'dysfunctional cognitive- interpersonal cycle' (Safran & Segal, 1990).

In summary, the therapeutic relationship has been perceived to have increasingly more importance over the last few decades as CBT has extended into working with more complex clients such as personality disorders. The therapeutic relationship has been distinguished as the background, the context in which therapy takes place, and also as a therapeutic construct, an intervention tool or a 'specific' factor in itself within CBT therapy. In this context, the inter-relational interactions offer the prospect of assessment and conceptualization and provide a guide to understanding and informing therapy interventions. This 'co creation' (Leahy, 2008) of intervention occurs as an 'ongoing process' (Leahy, 2008) of continual negotiation between the therapist and client. The therapeutic relationship has been conceptualized by many cognitive behavioural therapists (Leahy, 1993; Safran & Segal, 1990; Young, Klosko, & Weishaar, 2003) as an increasingly central component used alongside therapeutic techniques within treatment to facilitate change (Katzow & Safron, 2007; Persons, 2008). Further, this evolution of how the therapeutic relationship is understood has not only emphasized the importance of the therapeutic relationship, along with the interpersonal processes, but moreover, the importance of the therapist's contribution. When working in the interpersonal arena with more complex clients, the therapist' awareness of their schema and the potential affect that their schema can unknowingly have on the interpersonal relationship, is increasingly being seen as important (Leahy, 2001; Haarhoff, 2006). This is discussed next in chapter 3.

Chapter Three: Understanding the Therapeutic Relationship in Cognitive Behavioural Therapy

Chapter two discussed how the theoretical perceptions of the therapeutic relationship in CBT have changed in ways that have emphasised its increasing importance (Gilbert, 2000; Leahy, 2001; Safran & Muran, 2000; Young, Klosko, & Weishaar, 2003).

Chapter three looks at how the therapeutic relationship is understood in light of the changes and advancements within CBT theory and practice to expand into complex areas such as personality disorders. An overview of the influencing models is given and concepts of transference and counter transference are reviewed. Also, the role of social interaction and emotions within the therapeutic relationship, and the influence of attachment theory are discussed. In addition, the more recent influences in CBT of the role of compassion and mindfulness are reviewed. CBT theorists have increasingly reconceptualised so that these concepts and processes fit in with the principles of CBT.

These developments of expanding into working with more complex clinical challenges have not only emphasized the importance of the therapeutic relationship and the interpersonal aspects involved (Persons, 1989; Beck, Freeman, Davis, & Associates, 2004), but more specifically, the importance of the therapist being aware of their beliefs and schemas and how they can potentially

have a negative effect on therapy if there is a lack of awareness (Leahy, 2001; Haarhoff, 2006). The importance of Therapist Schema awareness will close the chapter.

Influencing Models

'Transference' and 'counter transference'.

'Transference'.

Transference, as a psychodynamic construct, was conceptualized by Freud (1912/1258) as a process whereby the client transferred the original unconscious childhood conflicts and fantasies onto the therapist. Therefore, the therapeutic relationship reflected the client's transfer of original conflicts onto the therapist, and was of central focus. It was where the process of psychoanalysis occurred, enabling the client to relive and bring to light the unconscious conflicts in the context of the therapeutic relationship (Miranda & Anderson, 2007; Leahy, 2001).

In social-cognitive terms, transference entails the totality of the personal and interpersonal relationship between the therapist and client in the conscious, accessible present moment (Leahy, 2007). It is the process by which mental representations are triggered by social contextual cues and applied to new individuals (Miranda & Anderson, 2007). Transference is also deeply intertwined with the core and the unspoken. An example of this could be 'schemata' which can be evident outside attention, but not necessarily unconscious (unreachable), and be brought into the conscious through identifying and increasing an awareness of it (Rudd & Joiner, 1997). Leahy (2007) further explains that the transference process includes personal schemas about the self and interpersonal

schemas and strategies about others. It also reflects the effect of both the client and therapist' past and present history of relationships (Leahy, 2007).

In addition, transference is not only evident on a cognitive level but is intertwined with affect and motivation (Greenberg, 2007; Miranda & Anderson, 2007). And on a final note, transference can include intra psychic processes, for example repression or denial (Leahy, 2007).

'Counter transference'.

Counter transference in psychodynamic terms is defined as the therapist's unconscious reaction to the client's transference (Kernberg, 1965; as cited in Rudd & Joiner, 1997). In CBT terms, counter transference is the therapist's reaction to the client. It differs from the psychodynamic unconscious drive theory terminology as it happens in the conscious, present, 'here and now'. It can include the cognitive, emotional and behavioural responses to the client. The counter transference has been conceptualized as including automatic thoughts, underlying assumptions, elicited beliefs, both personal and interpersonal schemas (Layden, Newman, Freeman, & Morse, 1993; Leahy, 2001), and varying emotional philosophies (Gottman, Katz, & Hooven, 1996; Leahy, 2008). In addition, it is reflective of earlier or current relationships (Leahy, 2007; Miranda & Anderson, 2007). Finally, Leahy (2001) extends the definition of counter transference to include the therapist's response to the client's resistance, or in other words, the therapist's reaction to the client's non compliance (Leahy, 2001).

The transference and counter transference concepts in CBT are now being increasingly articulated, compared to the past when they were acknowledged and articulated far less (Leahy, 2001). They include the automatic thoughts, intermediate beliefs, core beliefs and schemata, open to questioning by evidence

testing, just like any other beliefs. Both transference and counter transference are seen as a means for gaining insight and having therapeutic effects within the therapeutic relationship, (Greenberg & Mitchell, 1983; Clarkin, Yeomans, & Kernberg, 2006; as cited in Gilbert & Leahy, 2007). More importantly, if the transference and counter transference are out of the therapists' awareness then, unknowingly, ruptures in therapy can occur, especially when working within complex client scenarios, where the majority of the therapy occurs within the interpersonal arena.

Implications.

The therapist can use cognitive behavioural therapy to help him/herself identify, understand and then modify the counter transference, and in doing so, develop the therapeutic relationship and assist the client with modifying their interpersonal schemas and relationship patterns in treatment.

Understanding the transference and counter transference reactions in the therapeutic relationship can be especially useful with clients who present with interpersonal difficulties as it offers a 'window' into their past or current relationships outside of therapy (Leahy, 2001; Miranda & Anderson, 2007). For example, if the client appears to be devaluing the therapist, then most probably the client is devaluing other people in the 'real world' outside of therapy (Leahy, 2001). Rather than the therapist being emotionally aroused by the client's devaluing behaviour, the therapist could instead use the counter transference to benefit the interpersonal process. For instance, instead of the 'rejection-sensitive' (Leahy, 2001) therapist passively avoiding the devaluing behaviour due to their counter transference belief that 'conflicts are upsetting and I shouldn't raise issues that will bother the patient ' (Leahy, 2001), the therapist could instead be a role

model who does not retract back passively and avoid the client, but rather helps the client understand how his behaviour could be affecting others, starting with the affect that the client's devaluing has on the therapist. The client could then develop new more effective ways to relate towards others, starting with the therapist and then possibly these new more effective ways may ripple out into the client's relationships outside of the therapeutic scenario.

In addition, conceptualizing the transference and counter transference can assist in resolving ruptures that occur within the therapeutic relationship when maladaptive relational schemas have been triggered (Katzow & Safran, 2007). For instance, in working with ruptures, the therapist needs to accept that he/she is embedded in a maladaptive cycle with the client. The therapist and client are both contributing to a cycle of reaction and counter-reaction. By the therapist becoming aware of and reflecting on his/her own responses (counter transference) within the maladaptive cognitive-interpersonal cycle, a conceptualization of the transference and counter transference can be carried out. This conceptualization includes the therapist's own contribution to the maladaptive interaction cycle, and this awareness can help resolve the therapeutic impasse by the therapist starting the process with the client of collaboratively disengaging themselves from this cycle (Safran & Muran, 2000; Safran & Segal, 1990; Katzow & Safran, 2007). Katzow & Safran (2007) suggest that this conceptualization can be further facilitated by metacommunication between the therapist and client, "which is the practice of focusing on and communicating about the therapist-patient interaction as it occurs in session" (Katzow & Safran, 2007, p. 98). For instance, in the above example, the therapist and client could openly talk about and explore together their counter transference beliefs associated with the 'devaluing behaviour'

immediately in session in the moment it happens. So rather than a cycle of reacting to each other, they observe it occurring together, with no judgements, and openly discuss possible beneficial and productive ways to resolve the impasse together.

The role of social interaction.

There is a growing awareness of the influence of social interaction to affect psychological processes and therapy outcome (Safran & Segal, 1996; Cacioppo, Berston, Sheridan, & McClintock, 2000). As previously mentioned in chapter 2 (see chapter 2, p.25). Social Constructivism asserts that our understanding evolves through relationship and is constructed through our interrelations in social contexts (Gergen, 1985; Osbeck, 1993; Shotter, 1992). In other words, Burr (2003) clarifies that it is 'not found in individual psych or social structures, but in the interactive processes that take place routinely between people' (p.3). Therefore, the therapist and client evolve and grow together in the therapy context, each having an effect on each other. For instance, the client's way of thinking, their attitudes, their beliefs, their unique characteristics (for example, motivation or relationship history), and their social context, all has an effect on the therapist's way of thinking, their attitudes, and beliefs, and, vice versa. Hence, they are all part of the shared creating of the therapeutic relationship and thus in the inter-relational process (Gilbert & Leahy, 2007).

Further to this, Leahy (2007) explains how the therapeutic relationship is jointly developed through interactions which he calls 'interactional sequences'. Interactional sequences are the here and now interactional responses between the client and therapist (Leahy, 2007). For example, the therapist may give the client a compliment on how well they did in their university assignment but the client

sees this as a threat and withdraws. The therapist may then respond by pulling back, accompanied with screening what is said before future complimenting of the client's achievement(s). Similar to 'interactional sequences', the author more specifically explains these interactions as an 'interactive game' where the client and therapist play different roles as 'players' in this game, each reacting to each other with their own personal and emotional schemas, with their own set of rules for interacting in relationships, and with their 'transference' and 'counter transference' (Leahy, 2007). On a final note, of particular importance here, is how the therapist, when unaware, can easily slip into these interactive roles; and if unaware, this can result in obstacles and ruptures within the therapeutic process (Leahy, 2001). The importance of the interactional process of schema and beliefs between the client and therapist is discussed further in the closing of this chapter (see p. 49).

The role of emotional processing.

The role of emotional processing and working with strong emotions in the therapeutic relationship is being increasingly emphasized in CBT (Safran & Segal, 1996; Safran, 1998; Young, Klosko, & Weishaar, 2003), in dialectical behaviour therapy (DBT) (Linehan, 1993) and in emotion-focused therapy (EFT) (Greenberg, 2007).

The CBT model has always understood emotions to be important in the therapy process (Beck, 1995; Greenberger & Padesky, 1995), but it asserts that it is primarily through the cognitive process that change takes occurs. Therefore the emphasis has been on processing emotions through cognitive means by connecting the emotional reaction to a cognitive process (Beck, 1995; Greenberger & Padesky, 1995). For instance, Greenberger and Padesky (1995)

explain how strong emotions are linked to particular 'hot thoughts' (p. 55), and that these 'hot thoughts' drive the majority of moods/emotions. For example, in the last column of the 'thought record' CBT technique Greenberger and Padesky (1995) ask the client to rate in a percentage the 'hotness' of each thought by asking 'how much emotion you would experience based on that thought alone' (p. 59). Hence, in working with processing emotions in standard short-term CBT, the notion is for the therapist and client to identify the strong emotion, and most importantly, identify the associated thought(s) linked to the emotion, so, to be able to work with modifying the thought(s), thus indirectly changing the mood/emotion (Greenberger & Padesky, 1995).

Emotion-focused therapy (EFT) asserts that psychological change and emotional and mood regulating occur not only through the cognitive channel but also by emotional means. And the therapeutic relationship is seen as both the context and channel, or intervention tool in itself, by which this emotional processing occurs (Greenberg, 2007).

EFT views the therapeutic relationship as the context whereby the client is able to feel comfortable and supported enough to be able to process intense, overwhelming and often avoided emotions and feelings (Greenberg, 2007). Greenberg (2007) asserts that the therapeutic relationship and the therapist's overall persona need to reflect a spirit of 'empathy' (p. 43) and an environment of validation rather than just applying learned CBT techniques, for instance a thought record, to facilitate emotional processing (Greenberg, 2007). Schore, (2003) explains from an affective neuroscience perspective how areas of the brain involved in empathy and compassion development are affected by their significant others (Schore, 2003). Further, an empathetic therapeutic environment

enables these affected areas in the clients' brain to regulate in a new way, for instance, the client being able to apply empathy to one self and to be able to soothe and calm themselves (Greenberg, 2003).

In addition, Greenberg (2007) explains that the EFT approach involves working directly with the emotions and processing them with the therapist who is seen as an 'emotional coach' (p. 58), for example the therapist could help the client label and describe an emotion as it arises in therapy. The author also emphasizes the importance of the emotional responses of the therapist, for instance, always giving an unconditional response of empathy towards a crying client, and how this can beneficially affect the therapy process and outcome (Greenberg, 2007).

The growing emphasis being placed on the importance of the therapeutic relationship being the context and intervention where emotions can be processed reinforces the importance of the therapist's awareness of their own emotions and beliefs and how this sense of awareness and being, or as Greenberg (2007) describes 'therapeutic presence' (p.54), can have an effect on providing the best possible environment for emotional processing in the therapeutic relationship. As explained by Greenberg (2003), 'the kind of presence that seems to be therapeutic is the state of mind in which there is an awareness of moment-by-moment emotional reactions as well as thoughts and perceptions occurring in the client, in the therapist, and between them in the therapeutic relationship' (p. 54).

The notions of compassion, empathy, and validation are social-emotional experiences with their roots based in early attachment (Gilbert & Leahy, 2007). Attachment theory is presented next.

Attachment theory.

Problems in the therapeutic relationship can be improved through an understanding and an awareness of the role that 'attachment theory' (Bowlby, 1982; as cited in Liotti, 2007) plays in driving these issues. In chapter two we discussed how the therapist endeavours to establish the therapeutic relationship at the start through collaborative empiricism (Beck, 1979), and, it is then that the 'cooperative system' system is activated (Liotti, 2007). The 'attachment theory' is an evolutionary view of the attachment system being a system which facilitates care-seeking behaviour, expressed by 'internal working models'(IWS's), which are memory systems of how people will respond when one is in need (Bowlby, 1979; as cited in Liotti, 2007). The 'cooperative system' on the other hand, is the innate tendency to cooperate in a healthy equal way (Tomasello, 1999; as cited in Liotti, 2007), for example, the client and therapist interact on the same grounds.

In the 80's Guidano and Liotti (1983) started to incorporate attachment theory into CBT (Guidano & Liotti, 1983) and explain how problems in the therapeutic relationship can happen when the co-operative system shifts to the attachment system (Liotti, 2007). Thus, 'attachment-care giving interactions' (Liotti, 2007) between the therapist and client, for example, the therapist begins to see the client like a dependent and starts to feel the need to over protect the client, in the attachment system, activating an 'insecure' IWM for the client. This 'insecure' IWM is patterned from earlier unhealthy attachment relationships and carry insecure expectations for attachment, for example, that one will always get a violent response from a person with whom they are reaching out for help. And, if the therapist is able to be aware of and manage the client's insecure IWM, for example, the therapist shows empathy straight away towards the client by

validating the clients' extreme emotions (Leahy, 2001; Greenberg, 2007), whilst at the same time control for any of their own dysfunctional care-giving attitudes/schemas, for instance, their self sacrificing schema which will do anything to meet the clients' needs (Leahy, 2001), they will be able to then minimize the chance of confirming this insecure IWM. Hence, the therapist will succeed in being able to re-establish the cooperative system within the therapeutic relationship (Liotti, 2007).

On a final note, Liotti (2007) suggests that Parallel therapy, can be beneficial. Parallel therapy is when another therapist is used alongside the other therapist, and can be likened to parents meeting the many needs of a challenging child (Liotti, 2007). Hence, being useful when facing the client's intense transference and considering the therapist's counter transfer responses to this transference. For example, a client with borderline personality traits exhausts a therapist over a two week period with many phone calls pertaining to suicidal desires. When, the client finally does attempt to take their life, unsuccessfully, the therapist feels like they cannot continue with this client anymore. It is then that parallel therapy is advantageous, and another therapist, from the DBT (Linehan, 1993) group therapists treating this client, steps in and takes over working with this client. In this example the first therapist could be likened to a helpless parent with a challenging child, and the second therapist continues where the last therapist left off, offering the client seamless help and support. Thus preventing a repeat of childhood attachment trauma, such as a tired and helpless attachment figure, when one needs to be comforted and supported by a reliable and available attachment figure.

Implications could be seen in the importance of the therapist having an awareness of their own dysfunctional care-giving schemas, and being able to control them in order to minimize ruptures and the possibility of re traumatisation of the client if the schemas (care-giving)are left out of the therapists awareness (Leahy, 2001; Liotti, 2007).

Role of compassion and mindfulness.

The therapeutic relationship can be seen within a social and evolutionary context whereby human synchronicity and regulation exists within relation to each other, and one's sense of self is shaped and developed through social relationships (Safran & Segal, 1996; Gilbert, 2007). It is understood in CBT that a lot of problem emotions are based in these innate evolved systems and strategies (Beck, 1999 as cited in Gilbert, 2007), and as evolved social beings, Gilbert (2007) explains that 'the mind of one person can have an impact on the mind of another' (p.136). Hence, in the therapeutic relationship, the therapist's mind can have an influence on the client's mind (Gilbert, 2007). With CBT advancements into working within the interpersonal arena with complex clients, and more specifically with those clients with personality traits (Beck & Freeman, 1990; Layden, Newman, Freeman, & Morse, 1993; Linehan, 1993), an increasing importance has been placed on the interpersonal processes in CBT (Safran, 1998). Along with this, the role of compassion and mindfulness in the therapeutic relationship has been increasingly emphasized, being viewed both as a context for therapy and as an intervention tool in itself within these interpersonal therapeutic processes (Gilbert, 2007).

The notion of the therapist 'being compassionate' is described by Gilbert (2007) as 'loving, caring, forgiving, supportive and friendly' (p. 107) and 'non-

judgemental, empathetic' (p.127) to name but a few. In addition, a 'mindfulness approach' emphasizes the therapist observing non-judgementally and having an awareness of thoughts and feelings rather than focusing on trying to change them (Segal, Williams, & Teasdale, 2002; Katzow & Safran, 2007; Pierson & Hayes, 2007).

The literature suggests that the way the therapist is able to create a therapeutic environment that feels safe for the client, especially via the use of compassion, may facilitate a successful outcome (Gilbert, 2007). For instance when a client experiences the mind of another, such as the therapist, as 'compassionate', thus having access to a schema of others as warm and supportive, it can have a beneficial effect on them, helping them process strong emotions (Gilbert, 2007). For example, an overly self- critical client may present in therapy as feeling overwhelmed by a strong emotion such as shame, but when the therapist responds with compassion, they feel they can cope better, are more gentle on them self and feel more prepared to process the shame with the therapist. Further, not only do they feel comfortable enough to process these strong emotions, but as the client experiences the therapists' validating and compassionate way of thinking, this compassion received creates new 'internal conditions conducive to growth, maturation, change, healing and well-being' (Gilbert, 2007, p.107) and in time they may learn to apply the same approach of compassionate beliefs toward themselves. Conversely if a client experiences a therapist who has a condemning and critical approach, the opposite can be seen in the therapeutic relationship and this condemning and judgemental approach can result in having a negative effect on the interpersonal processes within the

therapeutic relationship (Gilbert, 2005a; Porges, 2001; Wang, 2005; as cited in Gilbert, 2007).

According to Gilbert (2007) the therapist can use an understanding of compassion to consider their own style of interacting. This practice is utilized at its best by the therapist when working with clients with interpersonal problems and with clients at challenging moments (Leahy, 2001; Segal, Williams, & Teasdale, 2002; Gilbert, 2007; Katzow & Safran, 2007). For instance, rather than the therapist instantly reacting to the transference by a counter transference response to the challenging client, they can instead, hold an awareness of it, identify it as existing and then simply observe it. Hence, by mindfully observing their counter transference beliefs, attitudes and schemas, they then have time to decide if it is necessary to address, change, or as Haarhoff (2006) suggests, adapt their schemas and beliefs to a more 'helpful and healthy alternative' (p.130) choosing to respond with, or in, compassion rather than reacting without this mindful interjection. In addition, in these difficult moments within the interpersonal arena, a mindfulness approach enables the therapist to discuss in a compassionate non-judgemental, non-reactionary way with the client and conceptualize the problems in a more considered, beneficial way (Gilbert, 2007; Katzow & Safran, 2007; Hayes, 2004; Pierson & Hayes, 2007). In other words, both compassion and mindfulness can be seen as contributing towards facilitating an increase in the therapist's awareness of their reactions and their own schemas, and an understanding of the affect it can have on the therapeutic relationship if the therapist is unaware of them and responds, for instance, without compassion.

The Importance of Therapist Schema Awareness

An important aspect to understanding the therapeutic relationship in CBT is the increasing emphasis on the importance of the therapists' understanding and awareness of their own beliefs and schemas and the potential effect that these beliefs and schemas can have on the therapeutic interpersonal processes (Safran & Segal, 1990; Layden, Newman, Freeman, & Morse, 1993; Beck, 1995; Greenberger & Padesky, 1995; Leahy, 2001; Bennett-Levy et al., 2001, 2003; Sanders & Wills, 2005; Haarhoff, 2006; Haarhoff & Kazantzis, 2007; Sutton, Townend, & Wright, 2007). The increasing focus placed on the therapeutic relationship and interpersonal processes when working with complex clients has called for the therapist to develop more self-awareness and to be able to identify their own schemas, beliefs, counter transference, and their blind spots as triggered within the therapeutic relationship (Leahy, 2001). This awareness, ability to reflect upon, and if need be, to address and use their own schema within the interpersonal arena, can facilitate successful treatment outcome. On the other hand, if it is out of the therapists' awareness, it has the potential to have a negative effect on therapy, interfering or inhibiting the therapeutic process and the opportunity toward a successful treatment outcome (Safran & Segal, 1996; Leahy, 2001; Haarhoff, 2006).

Traditionally, less emphasis has been placed on the importance of the therapist being aware of his or her own schemas and belief system(s). Neither has it been a focus in the training or supervision of CBT therapists (Bennett-Levy, 2001). This is mainly due to the confidence placed in CBT evidence based therapy interventions to focus on applying the correct technique and in following specific protocol for treatment packages with disorder specific clients (Wampold,

2001; Persons, 2008). For example, therapy for a disorder specific depressed client would focus on treating depression symptoms by following straight forward treatment packages and standard CBT techniques for depression. For instance, a technique commonly used would be the client filling out a weekly activity schedule with the aim to increase motivation. These standard CBT interventions are generally considered sufficient for the majority of the time in addressing the client's presenting problems without the need to focus on the interpersonal domain as an intervention (Persons, 2008), nor necessitate the therapist to have to work on increasing an awareness of their own schemas to benefit the therapeutic process.

Recently however, over the last two decades, with the advancements in CBT treatment approaches for more complex disorders such as personality disorders, therapy has extended into the interpersonal arena. This has led to an increase in the understanding of the importance of the therapists' contribution within the interpersonal process as the primary therapeutic work when the complex client's presenting problems is within the inter-relational arena. More specifically, the importance of the therapist being aware of his or her own beliefs and schemas, when triggered within the therapeutic relationship, has been increasingly emphasized (Leahy, 2001; Haarhoff, 2006).

Therapists can benefit from a greater awareness and understanding of their schemas. If the therapist has an awareness and insight into their schemas then they can be more equipped to evaluate and constructively use the counter transference and schemas when they arise, as triggered in the interpersonal process (Safran & Segal, 1996; Haarhoff, 2006; Persons, 2008). For example, a client arrives to therapy late, again, with their homework incomplete, complaining

to the therapist of the same complaint that the client had the week before; the topic that the homework was aimed to address. The therapist holds quite high expectations of self, clients, therapy, and time as the therapist has 'demanding standards' schema (Leahy, 2001). The therapist's first counter transference reaction to the client is the belief 'the patient should do the homework and the session should go according to plan' (Leahy, 2001). But instead, by the therapist being aware of their 'demanding standards' schema and accompanying beliefs which can lead to a tendency to have unrealistic expectations, the therapist is able to use this awareness constructively. Rather than reacting with an 'unhelpful' response (Haarhoff, 2006) and possibly creating a rupture in the therapeutic relationship, the therapist is able to avoid this by having a 'curious response' (Katzow & Safran, 2007), inquiring instead into finding out the reason for why the homework wasn't done and if there were any obstacles that they could problem solve together and plan for a future successful outcome. Therefore, by the therapist being aware of their counter transference schema, they are able to identify and use it in a way that provides, as Haarhoff (2006) describes, 'a more constructive response' or as a 'healthy alternative' response, thus facilitating the interpersonal process (Haarhoff, 2006).

Having an awareness of Therapist Schema is most important when there is an issue in therapy or when having to manage the interpersonal factors of the therapeutic relationship more efficiently with complex client issues (Leahy, 2001). In addition having an awareness of therapist schema can help therapists anticipate ruptures, or therapy interfering effects before they arise, hence, minimizing its occurrence (Leahy, 2001; Haarhoff, 2006; Leahy, 2007; Leahy, 2008). For instance, a therapist with 'special superior person' schema (Leahy,

2001), through developing an awareness of their narcissistic tendencies could for example, minimize interfering therapeutic effects by modifying their perspective. Leahy (2001) suggests that they could ask the question of themselves 'what would my life be like if I had to walk in the shoes of this patient' (p.251), thus developing an empathy for the client as a 'healthy alternative' (Haarhoff, 2006).

On the contrary, a lack of schema awareness can lead to problems and ruptures in the therapeutic relationship and can interfere with the interpersonal arena, thus, affecting negatively the change process and successful therapy outcome (Leahy, 2001; Katzow & Safran, 2007). For instance, if the therapist is unaware of their counter transference beliefs and schema then it can result in schematic mismatch, which is a clash between client and Therapist Schema, within the therapeutic relationship (Leahy, 2001). An illustration of schematic mismatch follows. A therapist with "excessive self- sacrifice" (Leahy, 2001) schema about therapy and relationships unknowingly confirms a client's "helplessness" and "dependent" negative personal schema about relationships. The therapist unknowingly enables this by constantly answering the client's out-of-session phone calls, hence not setting boundaries, and overall feeding into the client's "dependency" and "helplessness" schema. Hence, the therapist's lack of awareness of their "excessive self- sacrifice" schema interferes unknowingly with the client's treatment progress.

In addition to Therapist Schema affecting the interpersonal processes, they can also have a general effect on therapist's performance or on the therapy process if it remains outside of the therapists' awareness (Bennett-Levy & Thwaites, 2007). For example, the therapist could hold the belief "I have to cure all my patients". This belief could lead to the therapist having a driven approach

to therapy, and could possibly result in either a sense of irritation towards the client, or a feeling of discouragement if there was no progress in therapy. It could also lead to the therapist overworking themselves. Hence, it is important for the therapist to have an awareness of their schemas and beliefs to avoid these general effects that schema may have on the therapist's performance or on the therapy process.

To summarise, the understanding of the therapeutic relationship within CBT was reviewed, along with a number of models influencing its conceptualization. Concepts of transference and counter transference were reviewed. Further, the therapeutic relationship was explained as evolving and being created through social interaction. A brief overview of the influence of attachment theory was covered, and the roles that emotion, compassion, and mindfulness play in the interpersonal processes and the therapeutic relationship were discussed. Finally, the therapist's contribution to the therapeutic relationship, by the importance of them having an awareness of Therapist Schema, was discussed.

Chapter Four: Identifying Schema

There are a number of ways that the CBT therapist can use to identify schema and thus develop an awareness and understanding of his or her beliefs and schema as triggered by the therapeutic relationship. The following section discusses some of these ways, including Leahy's (2001) Therapist Schema Questionnaire (TSQ).

Using Standard Cognitive Behavioural Therapy Techniques

Using and practicing standard CBT techniques on oneself is one way the therapist can identify schema (Beck, 1995; Greenberger & Padesky, 1995; Bennett-Levy et al., 2001; Haarhoff, 2006), for instance, Beck (1995) states 'your growth as a cognitive therapist will be enhanced if you start applying the tools described in this book to yourself...begin to conceptualize your own thoughts and beliefs' (p. 10). The therapist could practice the CBT technique of filling out a thought record (Beck, 1995; Beck, 2004). For example they could fill out a thought record for a situation in a therapy session when they felt frustrated with a client with a personality disorder; they could then identify any automatic thoughts, intermediate beliefs or Therapist Schema seen in the thought record. Other useful CBT techniques could include the therapist identifying and rating mood: for instance doing a 'mood check' when triggered in therapy, as strong emotion often signals the presence of beliefs or schema (Beck, 1995). The therapist could also complete a five – part model (Padesky & Mooney, 1990), and this could help them understand and identify the interplay of cognitions (beliefs

and schema), emotions, physiology, and behaviour in a therapy situation when counter transference is triggered. In addition the therapist could fill out a 'cognitive conceptualization diagram' and then use this information to fill out a core belief worksheet (Beck, 1995), where the therapist could write down on the diagram the thoughts and emotions in which they felt a reaction to the client whilst in therapy. They could then continue to fill out the core belief worksheet by using core beliefs that they identified in the cognitive conceptualization diagram (Beck, 1995).

Behavioural experiments are another standard CBT technique which could be useful to identify schema. For instance, once implemented and carried out, outcomes could then be reflected upon (Beck, 1995). In addition, the therapist could use socratic questioning (Padesky, 1993). Or they could ask oneself questions using the 'downward arrow' technique (Greenberger & Padesky, 1995) to elicit core beliefs and schemas that they may have been experiencing in the therapy session when triggered. Using 'Imagery' (Young & Klosko, 1993) is yet another CBT technique that could help identify beliefs and schemas. For instance, images could be elicited that arise at trigger moments within the therapeutic relationship. Another technique could be that the therapist simply asks ones self directly when they notice an affect shift in therapy. This would be done in the same way that they would when eliciting automatic thoughts and beliefs with a client. For example they could ask the question 'what was going through my mind just then? (Beck, 1995)

Useful Self Report Questionnaires

A potential way to identify schema and increase the therapist awareness could be for the therapist to complete and score self- report questionnaires that are frequently used with clients to assess intermediate beliefs, core beliefs, and schema. When compared to other strategies, for instance, learning and applying CBT techniques on oneself, self-report questionnaires, require less training and are quick and efficient to carry out (Beck, Freeman, Davis, & Associates, 2004). Three relevant self-report questionnaires have been developed and tested: the Personality Belief Questionnaire (PBQ) (Beck & Beck, 1991), the Schema Quetionnaire (SQ) (Young & Brown, 1994), and the Dysfunctional Attitude Scale (DAS) (Weissman & Beck, 1978). Although these self-report questionnaires are designed for the client population, they could potentially be useful for therapists to identify schema that may have an impact on the therapeutic relationship and its processes.

The Personality Belief Questionnaire (PBQ).

The Personality Belief Questionnaire (PBQ) is grounded in cognitive theory and clinical observations. Beck, Freeman and Associates (1990) listed prototypical schema content containing sets of dysfunctional beliefs that match theoretically and clinically to corresponding personality disorders. Beck and Beck (1991) integrated these schema content belief sets into the PBQ self-report measure. The PBQ contains nine scales that can be conducted separately or jointly and that correspond to nine of the personality disorders on Axis II of the DSM-III-R.

The psychometric properties of an early version of the PBQ were investigated by Trull, Goodwin, Schopp, Hillenbrand, and Schusster (1993).

Good evidence was found for reliability but less support for validity for the various subscales among college students. Beck et al. (2001) tested the criterion validity of the PBQ in a sample of psychiatric outpatients. The reliability and validity of the PBQ was established empirically (Beck et al., 2001).

The Personality Belief Questionnaire – Short Form (PBQ-SF) was developed and it is concluded that the PBQ-SF is a practical alternative as a measure of personality disorder beliefs (Butler, Beck, & Cohen, 2007).

The Young Schema Questionnaire (SQ).

Schemas form the core of the individual's self-concept and guide the information regarding the self and the environment (Beck, Rush, Shaw, & Emery, 1979). Originally Young (1990) proposed 16 schemas based on the observations and reasoning of experienced clinicians. The Schema Questionnaire (SQ) was developed by Young and Brown (1994) to measure these early maladaptive schemas (EMS). This 205 item self-report inventory demonstrated adequate test-retest reliability and internal consistency as well as convergent and discriminant validity (Young, 1994). More recently, Young (2002) has increased the number of clinically observed EMSs to 18 (Young, 2002, as cited in Beck, Freeman, Davis, & Associates, 2004). The Young Schema Questionnaire has been translated into many languages, including French, Spanish, Dutch, Turkish, Japanese, Finnish, and Norwegian (Young, Klosko, & Weishaar, 2003). There is also a short form discussed below.

Schmidt, Joiner, Young, and Telch (1995) conducted a series of three studies to assess the psychometric properties of the SQ. They found support for 13 schemas in a factor analysis using a large college student sample. Schmidt (1995) also conducted a factor analysis among a small clinical sample. Fifteen of

the 16 factors hypothesised by Young (1990) were found to emerge. A hierarchical factor analysis identified three distinct higher order factors.

This study was replicated by a subsequent factor analysis of the SQ in a larger Australian clinical sample (Lee, Taylor, & Dunn, 1999). In accord with previous findings (Schmidt, 1995), 15 of the 16 originally proposed factors emerged.

The Schema Questionnaire – Short Form (SQ-SF) was developed and is comprised of a subset of 75 items from the original 205-item SQ and were thought to represent 15 early maladaptive schemas (Young, 1998). A following factor analysis of the SQ-SF with a clinical sample found 15 factors closely resembling the 15 schemas proposed by Young (Wellburn, Coristine, Dagg, Pontefract, & Jordan, 2002).

In addition, two further measures have since been developed. Namely the Young-Rygh Avoidance Inventory (YRAI-1) (Young & Rygh, 1994) and Young Compensation Inventory (YCI-1) (Young, 1995). The YRAI-1 is a 48 item scale which measures the degree to which a person utilizes various forms of schema avoidance, and the YCI-1 is a 40 item scale measures the most common ways that a person overcompensates for his or her schema.

The Dysfunctional Attitude Scale (DAS).

The Dysfunctional Attitude Scale (DAS) (Weissman & Beck, 1978) is a self-report questionnaire that measures a range of dysfunctional, negative, and perfectionist attitudes, for example “If you cannot do something well there is little point in doing it at all”. It was originally a 100-item scale and was further developed, based on factor analyses from a student population and is now comprised of two 40-item forms (Versions A and B), namely DAS-A and DAS-B.

The DAS-A is the most commonly used form and is suggested to have good internal consistency reliability, test-retest reliability, and replicable factor structure (Dobson & Breiter, 1983; as cited in Miller, 2007).

Personal Therapy

Personal therapy is another helpful way whereby the therapist can increase in their awareness of their schemas and beliefs. Personal therapy is where the therapist attends therapy, just as a client would, to have the opportunity to work through their personal issues, and increase their self-knowledge and self-awareness. This could help guard against 'blind spots' and areas in the therapists' personal life that could interfere with therapy. It has been used by therapists across different psychotherapy modalities and has been found to be subjectively helpful and beneficial in many ways including an increase in self-awareness (Norcross, 2005; as cited in Haarhoff & Farrand, 2012).

Traditionally, although personal therapy has always been useful, it has not been a priority for therapists in CBT. This lack of concern for personal therapy was due to the perspective discussed in chapter two, that of the therapeutic relationship being seen as background, with evidence-based technical interventions and CBT protocols taking the foreground and interpersonal processes and therapeutic relationship used as context or background (Wampold, 2001; Persons, 2008). The precedence was not focused so much on personal development or self-awareness, nor was it a requirement for accreditation in English speaking countries (Haarhoff & Farrand, 2012).

With CBT expanding into working with more complex client presentations and the increased focus on the therapeutic relationship affecting outcome,

personal therapy has become increasingly important. For instance, the effects from the therapist's personal life experiences that could potentially affect therapy could be minimized by the therapist engaging in personal therapy, and increasing their awareness and self- reflection (Ronnestad & Skovholt, 2003; as cited in Haarhoff & Farrand, 2012). For example, personal therapy could identify that a therapist could have 'self-schema' from childhood pertaining to lack of confidence such as 'inadequacy self-schema'. And by addressing this in personal therapy the potential to affect therapy is reduced.

Due to personal therapy not being prioritized in CBT, CBT therapists have had to attend personal therapy with therapists from other modalities, hence they have had to learn and practice techniques from that modality rather than from CBT (Laireiter & Willutzski, 2005; as cited in Haarhoff & Farrand, 2012). A consequence from this has been the therapist hasn't had the opportunity to practice and learn the specific CBT techniques on oneself in order to be able to identify their schema that could potentially affect therapy. Padesky (1996) explains 'to fully understand the process of the therapy, there is no substitute for using cognitive therapy methods on oneself' (p. 288). Neither is it certain that they have had the opportunity to reflect on the implications of their personal therapy on their interpersonal clinical practice as personal therapy tends to focus on the 'personal self' and 'self-schema' (Bennett-Levy, Thwaites, & Davis, 2009).

In addressing the above issues of practicing cognitive behavioural therapy techniques on oneself and reflecting on this process, an approach called 'Self-practice and self-reflection' or 'SP/SR' (Bennett-Levy, 2001) has been suggested, which is compatible with the CBT model. 'SP/SR' will be discussed next.

Self-practice/Self-reflection (SP/SR)

'Self-practice and Self-reflection' or 'SP/SR' (Bennett-Levy et al., 2001) is another route whereby the therapist can increase the awareness and identification of their own beliefs and schema. 'SP/SR' is a structured form of personal therapy that has been formalized to be used as a training tool, has no external therapist, and is compatible with the CBT model. Bennett-Levy et al., (2001) define Self-practice (SP) and Self-Reflection (SR) as 'practising cognitive therapy techniques on oneself' (p. 204). The 'Self-practice' (SP) component is when the therapist is essentially practising the actual cognitive therapy techniques or CBT therapy techniques on oneself, for example, filling out a thought record. The 'Self-reflection' (SR) component is when the therapist is observing, reflecting and evaluating the self-practice experience itself, for example, reflecting on the thoughts, emotions, and behaviours that the practice of filling out the thought record might bring up (Bennett-Levy et al., 2001).

The two components of experiential practice and reflection process from SP/SR have been shown to be useful tools to increase self-awareness, self-knowledge, and an awareness and understanding of one's thoughts and beliefs (Bennett-Levy et al., 2001; Bennett-Levy, Lee, Travers, Pohlman, & Hamernik, 2003; Haarhoff & Stenhouse, 2004; Sperry, 2010, as cited in Haarhoff & Farrand, 2012 ; Haarhoff, Gibson, & Flett, 2011), for instance, Bennett-Levy et al., (2001), describe how the experience of SP/SR brought about a 'deeper sense of knowing' (p. 209), and the participants reported an increased understanding of self and an increased awareness of the impact of one's own schemas (Bennett-Levy et al., 2001). In addition, Haarhoff and Stenhouse (2004) found that SP/SR resulted in

trainees reporting how they could see the importance of being able to identify their own schema when having to think about being in the role of the therapist. They could see the importance of having self-awareness and how SP/SR had helped them to become aware of how their own personal schemas could have the potential to affect the therapeutic relationship (Harrhoff & Stenhouse, 2004).

In another example, Haarhoff, Gibson, and Flett (2011) explain the role of SP/SR facilitating an enhanced self-awareness 'of the more subtle and complex aspects of the interplay between self and Therapist Schema' (p. 15). Here, SP/SR helped the participants to be able to identify and reflect on their belief systems and on how this might have an effect on the interpersonal therapeutic relationship (Haarhoff, Gibson, & Flett, 2011).

SP/SR has been applied within CBT training programmes and can help facilitate therapist self- awareness and therapeutic understanding, amongst other benefits and outcomes (Bennett -Levy, 2006; Bennett –Levy & Thwaites, 2007; Haarhoff & Farrand, 2012; Haarhoff, Gibson, & Flett, 2011). It can be carried out within pairs as 'co-therapists'; or individually in a workbook (Bennett-Levy, Thwaites, Chaddock, & Davis, 2009). Other examples in the literature to support SP/SR within training programmes to facilitate identifying schema and increasing awareness are the use of SP/SR workbooks (Haarhoff & Farrand, 2012), self-reflective journals and learning logs (Sutton, Townend, & Wright, 2007), and via web based on line reflective blogs (Farrand, Perry, & Linsley, 2010).

The 'Declarative-procedural-reflective' (DPR) Model

The declarative-procedural-reflective (DPR) model of therapist skill development (Bennett-Levy, 2006) provides a further useful framework whereby

the therapist can increase in the awareness and identification of their own beliefs and schema and also increase in an understanding of the effect this awareness has on therapeutic interpersonal processes. The DPR model is made up of three information-processing systems: the declarative system, the procedural system and the reflective system (Bennett-Levy, 2006). The three systems are integrated with one another.

The declarative system consists of interpersonal, conceptual, and technical knowledge, for example, something that may be read about, whereas the procedural system is a more complex system and includes the 'wisdom' expertise skills, for instance the 'when-then' rules, that come into being and develop over time once the declarative knowledge has been applied and put into practice and reflected on (Bennett-Levy, 2006; Bennett-Levy & Thwaites, 2007). Bennett-Levy and Thwaites (2007) explain that the third system, the reflective system, contains no knowledge or skill base, and consists of self-reflection and general reflection skills that only become operative when there is an issue that needs to be attended to and reflected upon. This need for reflection could come into play when there is an interpersonal problem that arises in the therapeutic relationship, such as a clash between the client and therapist schemas (Leahy, 2001), when there are ruptures in the therapeutic relationship (Katzow & Safran (2007), or when therapists realize a discrepancy between something occurring and what they have known to be true (Niemi & Tiuraniemi, 2010). It is in these circumstances that attention and reflection on the issue is needed (Bennett-Levy, 2006).

The therapist's use of reflective skills, thus, developing the DPR reflective system has been shown to be helpful in facilitating therapist self-awareness. Use of the reflective system enables the therapist to increase in their understanding of

their schema and belief system, and its potential impact on the therapeutic relationship and the therapy interpersonal processes if there is a lack of awareness (Bennett-Levy et al., 2001; Bennett-Levy, Thwaites, Chaddock, & Davis, 2009; Haarhoff, Gibson, & Flett, 2011).

The DPR model provides a framework in which the therapist can identify the particular interpersonal problem area(s) in the therapeutic relationship. For instance, the DPR model explains how both the personal self-schema and the professional self-as-therapist schema form parts of the procedural system skill development. Further, it explains the importance of being able to differentiate between the two through reflection, so that certain problematic self-schema can be identified and worked on, and new interpersonal skills developed to enhance the therapeutic relationship (Bennett-Levy & Thwaites, 2007). For instance, Niemi and Tiuraniemi (2010) suggest that engaging in self-reflection and reflective skills may be important in the 'accommodation' (p.267)process of prior knowledge, for example, self –schema beliefs about self, developing into the new knowledge, for instance, 'self-as-therapist' schema.

In summary, as the therapist increases in the awareness of how these information processing systems, such as the procedural and reflective systems, interact with each other, the better they will be able to manage the interpersonal arena, for instance, being aware of their 'blind spots' and identifying schema that may influence the therapeutic relationship (Haarhoff, Gibson, & Flett, 2011).

The 'Therapist Belief System' (TBS) Conceptual Model

The Therapeutic Belief System (TBS) (Rudd & Joiner, 1997) is a useful framework for understanding the beliefs within the therapeutic relationship in

CBT, in a way that is compatible with the CBT model. As described in more detail in chapter 1, this model is an interactive system, enabling the therapist and the client to identify beliefs and schemas about self, the client or therapist, and also the process of treatment itself (Rudd & Joiner, 1997). For instance, the therapist belief system (TBS) diagram could be completed by the therapist, to identify counter transference beliefs and schemas after a reaction is felt in therapy. The therapist could detail their own response to the situation under each treatment component (client, self, treatment process). Thus, once the (TBS) diagram is completed, the therapist is able to identify both automatic thoughts and core beliefs under each treatment component. For example under the treatment component of self, the therapist would be able to see oneself shifting along the continuum from a potential victimizer, to collaborator/partner, to saviour, and the potential beliefs associated with each could be identified. For instance a 'saviour' core belief about treatment could be identified as 'only I can help this client', similarly a 'saviour' assumption about self could be identified as 'if I don't do everything for this client, treatment will fail' (Rudd & Joiner, 1997).

The Therapist Schema Questionnaire (TSQ)

The Therapists' Schema Questionnaire (TSQ) (Leahy, 2001) is a self-report inventory designed to identify the Therapist Schema which could influence the therapeutic relationship (see Appendix E & Appendix F). The TSQ consists of 46 items and was developed by Leahy (2001) to measure 15 common Therapist Schemas evident in the therapeutic relationship. Each proposed Therapist Schema is represented in the questionnaire by one to four items. For example, the item 'I must always meet the highest standards' is one of the items representing

the “demanding standards” Therapist Schema (for more detail on the TSQ see chapter 1, p. 26; Appendix E & Appendix F). The items of the TSQ were derived from Leahy’s clinical experience and clinical observations (Leahy, 2001).

To date, the literature review reveals one study related to the TSQ. Haarhoff (2006) conducted a study on “the importance of identifying and understanding Therapist Schema in CBT training and supervision” (Haarhoff, 2006). In this study, four groups of CBT trainees completed the TSQ. The most common Therapist Schema found across all the four groups was “demanding standards”, “special superior person”, and “excessive self-sacrifice”. This study revealed some of the ways Therapist Schema can have a negative effect on the therapeutic relationship if not identified out of the trainee’s awareness. For example, a trainee with the “excessive self-sacrifice” Therapist Schema, may not be assertive enough and avoid important components of anxiety treatment exposure therapy as he or she may not want to upset the client (Haarhoff, 2006).

This study also demonstrates how the TSQ can be used in training and supervision as a helpful technique in the identification of transference and counter -transference processes, in a way that is consistent with the conceptual underpinnings of cognitive behavioural therapy (Haarhoff, 2006). The paper outlines practical ways in which the TSQ can be used in training and supervision. Firstly, the TSQ can be used to increase the trainee’s insight. For example, if a lot of significant Therapist Schema surface then this may signal that the trainee is anxious or depressed. Similarly, the TSQ could be used as “a screening device” to identify potential Therapist Schema that could interfere with therapy. For example, a trainee may have certain Therapist Schema that may signal that the trainee has his or her own interpersonal challenges that may need to be addressed

before attempting to work with clients with complex issues such as personality disorders that could potentially trigger counter transference schemas. In addition, Haarhoff (2006) suggests that the TSQ could be useful to extract "general themes" such as the "demanding standards" theme, thus helping the trainee to be aware of, in this instance, their high expectations of therapy of which they could be unknowingly transferring onto their clients. Hence, once identified, the Therapist Schema of concern can be conceptualized in supervision using the cognitive behavioural model. Thus, "unhelpful strategies", for example being controlling towards a client by a trainee who has the "demanding standards" Therapist Schema, can be avoided and "healthy alternative" strategies can then be implemented. An example of a "healthy alternative" could be practicing decreasing control by allowing the client to take control of choices in agenda setting (Haarhoff, 2006).

Although the importance for successful CBT outcome, in identifying, being aware of and understanding Therapist Schema as triggered by the counter transference in the therapeutic relationship, has increasingly been emphasized (Safran & Segal, 1996; Rudd & Joiner, 1997; Leahy, 2001; Haarhoff, 2006), the Therapist Schema Questionnaire has received no psychometric validation as of yet. It is, thus, the intention of this study to make known the underlying factor structure of the TSQ, along with its reliability.

To summarize, chapter one outlined the CBT model and the concept of the schema in CBT. It reviewed schema theory, with particular reference to the importance of Therapist Schema in CBT. Chapter two and three described how the developments in CBT of expanding into working with complex challenges have encouraged an increasing focus being placed on the therapeutic relationship

and interpersonal processes. For the majority of the time the therapeutic relationship serves well as a context whereby a 'good collaborative working relationship' is sufficient in the treatment of disorder specific clients. But, with the expansion of CBT working with more complex clients in the interpersonal arena, it also requires that the therapist understand and use the therapeutic relationship as an intervention tool for successful treatment outcome, especially when working with complex clients and when issues are trigged in the interpersonal arena. Therefore to manage the transference, counter transference, obstacles, ruptures and systematic mismatch, the therapist needs to be aware of their own schemas and belief system(s) and have the ability to self-reflect and self- observe (Leahy, 2001). This is important because as mentioned already in chapter three, the therapist's awareness of their schema can facilitate successful interpersonal processes by identifying and constructively using it, whereas, if they are out of the therapist's awareness, ruptures in the interpersonal processes can happen as default from being ignored (Leahy, 2001; Haarhoff, 2006). Chapter four outlined useful ways the therapist could potentially identify schema, as suggested in the CBT literature. The Therapist Schema Questionnaire (TSQ) being one of these useful ways to identify Therapist Schema (Leahy, 2001; Haarhoff, 2006).

The Present Study

The present study aimed to investigate the psychometric properties of the TSQ by exploring the underlying factor structure, along with its reliability among a group of therapists (n=269). More specifically, the following investigations were undertaken:

1. Firstly, the study aimed to investigate whether or not the items of the TSQ cluster into separate groups of homogenous items (factors) that represent underlying therapist schema. And, if they did form these clusters, how many factors emerged in the factor structure? And, what is the interpretation of these factors?

2. Secondly, the study aimed to explore more closely the factors (schemas) that emerged and to compare them with Leahy's (2001) clinical observations of Therapist Schemas. The three following questions were asked:
    a. Which of the 15 schemas that Leahy (2001) suggest, emerge?
    b. Are any of the independent schemas a combination of Leahy's schemas merged together?
    c. Do any additional schemas emerge?

3. Thirdly, the study aimed to evaluate the reliability of firstly the final refined schemas that emerged and secondly the reliability of the final refined TSQ scale. Further, these questions were asked:
    a. Do the items of each factor/schema that emerged show good internal consistency?
    b. Does the final refined TSQ measure as a whole show good internal consistency?

4. Fourthly, the study investigated the correlations /strength of the relationships between the refined factors/schemas.

5. The final aim was to look into what were the most commonly identified Therapist Schemas seen in the therapist sample.

Chapter Five: Method

The literature review provided a backdrop for the study, highlighting the increasing importance placed on the therapeutic relationship in CBT, and on the therapists' contribution to the therapeutic relationship, facilitated through an awareness of their own belief system and schemas, and of the potential affect it can have on the therapeutic process if outside of the therapists' awareness, especially when working in the interpersonal arena (Safran & Segal, 1996; Rudd & Joiner, 1997; Leahy, 2001; Haarhoff, 2006). Utilizing the Therapist Schema Questionnaire (TSQ) (Leahy, 2001) was seen in the literature review as one potential way to identify and screen for Therapist Schema (Leahy, 2001; Haarhoff, 2006).

At the time of writing, there has been no research that has evaluated the psychometric properties of the TSQ. The present study utilized the ratings of the TSQ within a sample of therapists (n=269) to investigate the psychometric properties of the TSQ by exploring the factor structure, along with its reliability.

This chapter outlines the research design, the participants involved in the research, the recruitment process, the measures used, the procedure used, and the data analysis.

Research Design

A non- experimental survey design was the data collection strategy used. An exploratory quantitative research design was used as no previous studies have examined the Therapist's Schema Questionnaire (TSQ) (Leahy, 2001) psychometrics.

There was one study undertaken, this being Exploratory factor analysis (EFA). EFA was used as there was no existing theory about the factors that were responsible

for the TSQ observed responses. The number of factors to explain the interrelationships between the items was not known (Gorsuch, 1983; Pedhazur & Schmelkin, 1991; Tabachnich & Fidell, 2001; as cited in Pett, Lackey & Sullivan, 2003). Thus, the emphasis was to replace a set of variables with a smaller set of underlying factors that would emerge, accentuating the theoretical importance that these underlying sets of factors would be seen as explaining the pattern of the data (Spicer, 2005). Hence, the main aim was to explore and examine the factor structure and the interrelationships among the variables of the TSQ measure.

Participants

Participants were drawn from a range of professional disciplines: psychologists, psychotherapists, social workers, psychiatrists, counsellors and other mental health practitioners employed in both public and private mental health settings. Demographic data was collected for 64% of the sample and is summarised in Table 1 (see Table 1). The remainder of the sample (36%) were trainees or graduates from a Postgraduate Diploma of CBT and represented once again a range of mental health professionals including psychologists, psychotherapists, counsellors, social workers, nurses, psychiatric registrars, and general practitioners. Demographics for the 64% of the sample demonstrated participants varied in terms of age, gender, professional discipline, work sector (whether private or public), and in ethnicity. The participants ranged in age from 20-69 (mean age = 44.5 years). In order to complete the TSQ, participants were required to have the experience of working therapeutically with clients.

For the purpose of this research, the term ‘therapist’ refers to a mental health practitioner who is a trained individual (Wampold, 2001), such as a psychologist,

psychiatrist, counsellor, psychotherapist, occupational therapist, nurse, social worker who treats psychological, emotional, behaviour disorders through interpersonal communications (psychological techniques and principles, rather than by physical means). As explained by Wampold (2001), "the term 'interpersonal' implies that the interaction transpires face-to-face and thus rules out telephone counselling or interactions via computer" (p. 3). Therapists that utilized treatments that did not have a psychological basis, for example, herbalists or naturopaths, were excluded. The age, gender, professional discipline, years of experience, work sector (whether private or public), the approximate number of hours spent doing client face to face therapy per week, model of psychotherapy used, and the ethnicity of the participants were included in the demographics.

Table 1

Summary of Demographic Characteristics of the Sample (N=172)

Variable		*N*	*%*
Gender	Male	48	28.0
	Female	124	72.1
Age	Range	20-69	
	Mean	44.5	
Profession	Psychologist	58	80.6
	Psychotherapist	18	10.5
	Social worker	14	8.1
	Psychiatrist	11	6.4
	Counsellor	37	21.5
	Nurse	13	7.6
	Occupational therapist	5	2.9
	Community mental health worker	5	2.9
	CBT practicum trainee	11	6.4
Work Sector	Private	54	31.4
	Public	87	50.6
	Private + public	31	18.0
Ethnicity	New Zealand – Pakeha	92	53.5
	Pacific Islander	4	2.3
	Maori	1	.6
	Asian	15	8.7
	Other European	38	22.9
	Pakeha + Maori	4	2.3
	Other	18	10.5

Recruitment process.

Non probability sampling methods were performed. Non probability sampling refers to a selection procedure which is not based on randomly selecting participants from a population. Hence, some elements in the population have a zero or unknown probability of being selected (Visser, Krosnick, & Lavrakas, 2000). Non probability sampling was sufficient to be used as the scientific value did not depend on generalizing the results to a population. Rather, the objectives were to test whether a particular process occurs at all, to identify the underlying factor structure of the questionnaire (Visser, Krosnick, & Lavrakas, 2000).

There were a number of ways participants were recruited. Initially, haphazard sampling (Visser, Krosnick, & Lavrakas, 2000) was used to recruit participants. Newsletter advertising in appropriate agencies such as The New Zealand Psychology Society (NZPsS) and Aotearoa New Zealand Association for Cognitive Behavioural Therapy (AnZaCBT) was placed (see Appendix C). There was no response to these advertisements. In addition, emails were sent to psychology and counselling practices inquiring into the process of placing an advertisement in their newsletters or utilizing their mailing list/data base of their therapists (see Appendix D). As a result, mailing lists, data bases, and advertisements were declined. Thus, the on-line option was abandoned. However, the agencies recommended communicating separately with each therapist. Hence, the option of contacting therapists individually by mail was next explored.

Purposive sampling (Visser, Krosnick, & Lavrakas, 2000) was used. Purposive sampling involves haphazardly selecting members of a particular known group within a

population (Visser, Krosnick, & Lavrakas, 2000). Participants were obtained through the New Zealand Business directory. Psychology, counselling, and therapy practices were targeted. The individuals within each practice, whom could be identified, were utilized. Three hundred questionnaires were posted out to counsellors, psychologists, and therapists throughout New Zealand.

Conjointly, haphazard convenience samples (Visser, Krosnick, & Lavrakas, 2000) were included in the recruitment process. Trainees currently enrolled in the Massey University Post-Graduate Diploma in Cognitive Behaviour Therapy (CBT), and psychologists from the Massey University School of Psychology were invited to complete the questionnaire.

In addition, snowball sampling (Visser, Krosnick, & Lavrakas, 2000) proved beneficial with eighty five questionnaires given out. This variant of purposive sampling took advantage of the researcher's contacts within the field of mental health. Community Mental Health Centres in Auckland were visited in person by the researcher and their employees recruited to partake in the research. Further, colleagues of the researcher were asked to participate. Each of these contacts, in turn, were asked to suggest other members of the subpopulation for the researcher to contact and post questionnaires out to. The researcher's contacts were followed up with a phone call to enhance the response rate.

Lastly, trainees enrolled in a Massey University Post-Graduate Diploma in Cognitive Behaviour Therapy were asked to participate. Also graduates from a Post-Graduate Diploma in CBT were asked to participate.

In summary, 500 questionnaires were distributed and 269 participants were recruited.

Measure

The Therapists' Schema Questionnaire (TSQ) (Leahy, 2001) is a qualitative self-report measure and consists of 46 items (see chapter one, pg 14). Each item is an assumption, for example "If the patient isn't happy with me, then it means I'm doing something wrong". Individual assumptions are grouped to represent fifteen common Therapist Schemas, identified by Leahy, evident in the therapeutic relationship. The following therapist schema are identified; demanding standards, special superior person, rejection sensitive, abandonment, autonomy, control, judgmental, persecution, need for approval, need to like others, withholding, helplessness, goal inhibition, self-sacrifice, emotional inhibition Each proposed therapist schema is represented in the questionnaire by 1 to 4 assumptions. For example, 'I must always meet the highest standards' (Demanding standards) (for more detail see chapter one, pg 14 and Appendix F). The items of the TSQ were derived from Leahy's clinical experience and clinical observations (Leahy, 2001). And, at the time of writing no research has evaluated the psychometric properties of the TSQ.

Each assumption is scored on a six-point Likert scale. The participants were asked to think about the current clients that they were seeing for therapy and to rate the degree of their belief in each assumption from 1 – 6, with 1 = very untrue, 2 = somewhat untrue, 3 = slightly untrue, 4 = slightly true, 5 = somewhat true, and 6 = very true. The TSQ takes approximately 5 – 10 minutes to complete.

Procedure

The research was evaluated by peer review and judged to be low risk. Consequently, it was not necessary to be reviewed by one of the University's Human Ethics Committee and the researcher was responsible for the ethical conduct of the

research. The return of the questionnaire implied consent. Participants had the right to decline to answer any particular question. They were also informed that the study was based on total anonymity and free will (see Appendix A).

The data collection mode used was self-administered questionnaires. The questionnaires were sent out by post, along with an information sheet, which provided an introduction and invitation to the research, and with instructions on how to return the completed survey (see Appendix A). In addition, a demographic sheet preceded the questionnaire (see Appendix B). The study involved each participant completing the 'Leahy's Therapist Schema Questionnaire' anonymously, and returning the completed questionnaire in the enclosed self-addressed and pre-paid envelope. In addition, participants were reminded that there were no right or wrong answers and to avoid giving answers that they thought would be desirable.

Finally, the age, gender, professional discipline, years of experience, work sector (whether private or public), the approximate number of hours spent doing client face to face therapy per week, model of psychotherapy used, and the ethnicity of the participants were included in the demographics.

Analysis

The data was quantitative, and statistical analysis was carried out using SPSS Statistical Version 19 (SPSS, 2011).

This is an exploratory factor analysis. That is, although the 46 variables being measured are considered to be relevant to the primary research questions, there is no existing theory about the relationships that will emerge between them. Therefore, the main objective was to examine these relationships underlying the 46 scale items, and further, make statements about the factor structure of the measure.

Chapter Six: Results

Preliminary Data Analysis

The TSQ measure holds continuous data based on an ordinal-level Likert type scale of 1 – 6. Demographic data was available. Age, gender, professional discipline, years of experience, work sector, model of psychotherapy used, and ethnicity were converted to categorical numerical variables, and the number of face to face hours was recorded as a continuous variable. Preliminary data checking was carried out to screen the data set for errors, missing data, possible outliers, and to assess normality.

Missing Data

Missing value descriptive checks were carried out on the data, and these analyses showed that there was a minimal amount of missing data, with 26 out of the total 269 cases (9%) having between one and four of the 46 items left blank. Closer examination of the missing data cases revealed possible non-random patterns for a small amount of the data and the majority of the missing values appeared to be happening randomly. A possible systematic pattern was seen with item three (‘my patients should do an excellent job’). In seven of the cases, it looked as if the participants had decided to leave out item three due to it being unclear or ambiguous to them. It was decided to retain the data from these seven cases in the analysis, and to use similar response patterns from other participants as a template to input the missing value, thus, providing the rationale for each imputation of non- random missing data.

The residual missing data consisted of nineteen cases and did not seem to have any systematic pattern. Therefore, it was concluded that the missing values appeared

to be purely random, and so, it was decided to use the SPSS 'Missing Value Analysis' for the imputation of the random missing data.

Normality and Outliers

Descriptive statistics including the mean, standard deviation, skewness and kurtosis values were obtained for the 15 TSQ subscales (see Table 2). The significance levels of the Kolmogorov-Smirnov statistic for the 15 TSQ subscales suggested violation of the assumption of normality. This is a common occurrence in large samples (Pallant, 2011), and further analyses of normality were carried out. Normality was assessed, as recommended by Taachnick and Fidell (2007), by investigating histograms, box plots, the Normal Q-Q Plots, and Detrended Normal Q-Q Plots (Tabachnick & Fidell, 2007; as cited in Pallant, 2011), and suggested the data was not overly skewed. Additional analysis was carried out using guidelines by West, Finch, and Currie (1995). In observing the skewness and kurtosis values, West, Finch, and Currie (1995) recommend a cut-off score for skewness = 2 and kurtosis = 7. The items in these subscales met the required standards for normality, hence, it was decided that data transformations were not necessary.

An investigation for outliers was undertaken. Three out of the 15 schema subscales revealed genuine outliers, not due to error. The mean and the trimmed mean were compared in these schema subscales containing outliers, and they were all found to have very similar mean and trimmed mean scores, and consequently was not found to have a strong influence on the mean. Given that the mean and trimmed mean were very similar, and the fact that the extreme values were not too different from the remaining distribution; it was decided to retain these outlying cases in the data file. The study reports the factor analysis next.

Table 2

Mean Total Subscale Scores, Skew, and Kurtosis for the TSQ Subscales

Subscale Schema	*N*	Mean (*SD*)	Skewness	Kurtosis
Demanding standards	269	12.73 (4.17)	-.10	-.51
Special, superior Person	269	11.69 (3.19)	-.34	-.12
Rejection-sensitive	269	5.36 (2.12)	.22	-.25
Abandonment	269	8.96 (2.76)	.16	-.29
Autonomy	269	9.17 (3.10)	.66	.38
Control	269	2.13 (1.27)	.75	-.78
Judgmental	269	5.21 (2.51)	.42	-.61
Persecution	269	7.68 (2.90)	.78	.12
Need for approval	269	6.27 (2.28)	-.11	-.56
Need to like others	269	8.22 (3.02)	.22	-.46
Withholding	269	7.50 (2.59)	.17	-.46
Helplessness	269	12.10 (4.44)	.05	-.73
Goal inhibition	269	5.39 (2.40)	.88	.03
Excessive self-sacrifice	269	13.06 (4.13)	-.29	-.31
Emotional inhibition	269	6.20 (2.84)	.84	.30

Factor Analysis

Choice of factor extraction and rotation method.

An exploratory factor analysis (EFA) was used to apply principal components analysis (PCA) to the data and an oblimin rotation solution was reported.

An EFA was used based on the fact that there was no existing theory about the factors and the number of factors to explain the interrelationships among the items; this was unknown (Gorsuch, 1983, as cited in Pett, Lackey & Sullivan, 2003; Tabachnick & Fidell, 2001).

The decision made to use principal components analysis (PCA), rather than common factor analysis (CFA), principal axis factoring (PAF) or parallel analysis, was based on the fact that the aim of the research was to explore the interrelationships among the set of 46 items in the TSQ and to summarize with a smaller set of uncorrelated factors that explain the factor structure of the data set. Tabacknich & Fidell (2001) explain that PCA is especially useful when the aim is to summarize a large set of variables with a smaller number of components (Tabachnick & Fidell, 2001). In addition, Pett, Lackey and Sullivan (2003) suggest that for EFA, you commence with PCA, come up with an initial solution, and compare this result with a CFA and PAF solution. The choice of which extraction approach to use is the solution that holds both the best fit and that intuitively makes the most sense (Pett, Lackey & Sullivan, 2003). Given that this was the case with the PCA approach, along with the objectives of this study, PCA was the favoured choice of factor analysis to use.

Both orthogonal and oblique rotation solutions were initially applied to the data, they were interpreted and compared. It was decided to be most appropriate to report the oblique rotation method, which performed the direct oblimin rotation, because it both provided a clearer picture of the factors and because there appeared to exist some correlation, although low, amongst two or more of the factors being rotated. Therefore as Pett, Lackey, and Sullivan (2003) suggest, if some degree of correlation exists between subscales, then it is suggested to use the Oblique rotation method. The study reports the suitability of the data for factor analysis next.

Suitability of the Data Set for Factor Analysis

Before performing PCA, the data set was assessed to ensure the suitability for factor analysis, in other words, that the variables in the data set are sufficiently

interconnected to make them 'factorable' (Spicer, 2005). The sample size and the strength of the relationship among the items were assessed. The first issue to be assessed was the sample size. The sample contained 269 cases. There is little agreement among authors on factor analysis regarding sample size, and some suggest that it is the ratio of participants to items that is of concern (Pallent, 2011). Nunnally (1978) suggests that a sample of at least ten participants per item is needed (Nunnally, 1978; as cited in Pett, Lackey & Sullivan, 2003), whilst Hair et al. (1995) say that a sample of at least 100, or at least five participants per item is warranted. In addition, Tabachnick and Fidell (2001) recommend that a sample of 300 is ample for factor analysis to proceed. Although the sample is slightly smaller than this suggestion of 300 participants (Tabachnick& Fidell, 2001), the minimum amount of 269 is sufficient, and reaches the criterion guidelines set by Hair et al (1995), with this study's 269 cases, and 5.8 cases per variable.

Secondly, the strength of the inter-correlations among the items was assessed. Inspection of the correlation matrix indicated that many coefficients of .30 and above, were present (see Appendix H), showing that the data was suitable for factor analysis. In addition, the Kaiser-Meyer-Olkin (KMO) value was .82. This value was more than the recommended criterion value of .60, thus considered "meritorious", according to the Kaiser criterions (Kaiser, 1970, 1974; as cited in Pett, Lackey, & Sullivan, 2003). Also, according to Bartlett's Test of Sphericity (Bartlett 1954; as cited in Pallant, 2011), the correlation matrix is not an identity matrix (i.e., that there is no relationship among the items), having a value of $p<.000$. Thus, it reached the significance levels recommended of $p< .05$, also supporting the factorability of the correlation matrix. These findings conclude that there was a sufficient sample size relative to the number of items in the scale and that the correlations among the individual items are strong

enough. Given these findings, the study reports the initial unrotated factor extraction next.

Initial Factor Extraction

The 46 items of the Therapist Schema Questionaire (TSQ) were subjected to principal components analysis (PCA). Several criteria were used to help decide how many initial factors to extract for the TSQ. This criteria retention included looking at the eigenvalues, percentage of variance extracted, and examining the screeplot.

As suggested by Pett, Lackey and Sullivan (2003), the Kaiser-Guttman rule revealed that thirteen components had eigenvalues of one or more, explaining 62.63% of the variance (see Table 3).

Table 3

EFA results from Principal Component Analysis, with No Specified Number of Factors, extracted from Total Variance Explained Matrix

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	8.66	18.83	18.83	8.66	18.83	18.83	4.92
2	3.76	8.18	27.01	3.76	8.18	27.01	2.97
3	2.49	5.41	32.42	2.49	5.41	32.42	3.72
4	2.11	4.59	37.01	2.11	4.59	37.01	2.52
5	1.82	3.95	40.96	1.82	3.95	40.96	2.85
6	1.60	3.48	44.43	1.60	3.48	44.43	3.28
7	1.39	3.01	47.44	1.39	3.01	47.44	3.19
8	1.32	2.90	50.31				
9	1.26	2.73	53.04				
10	1.19	2.59	55.63				
11	1.10	2.39	58.02				
12	1.07	2.31	60.33				
13	1.06	2.29	62.63				

Note. When components are correlated, sum of squared loadings cannot be added to obtain a total variance

Secondly, the scree test was undertaken by examining the screeplot (Catell 1966; as cited in Pallant, 2011) for the TSQ scale. An inspection of the screeplot revealed a break between the sixth and seventh factor (see Figure 1). Although, it was not completely clear whether to err towards extracting six or seven factors. Gorsuch (1983) suggests that if there is any doubt of how many factors to extract then it is best to select more rather than less factors, thus, it was decided to lean towards selecting

seven factors (Gorsuch, 1983; as cited in Pett, Lackey & Sullivan, 2003). The seven component solution explained a total of 47.44% of the variance (see Table 3).

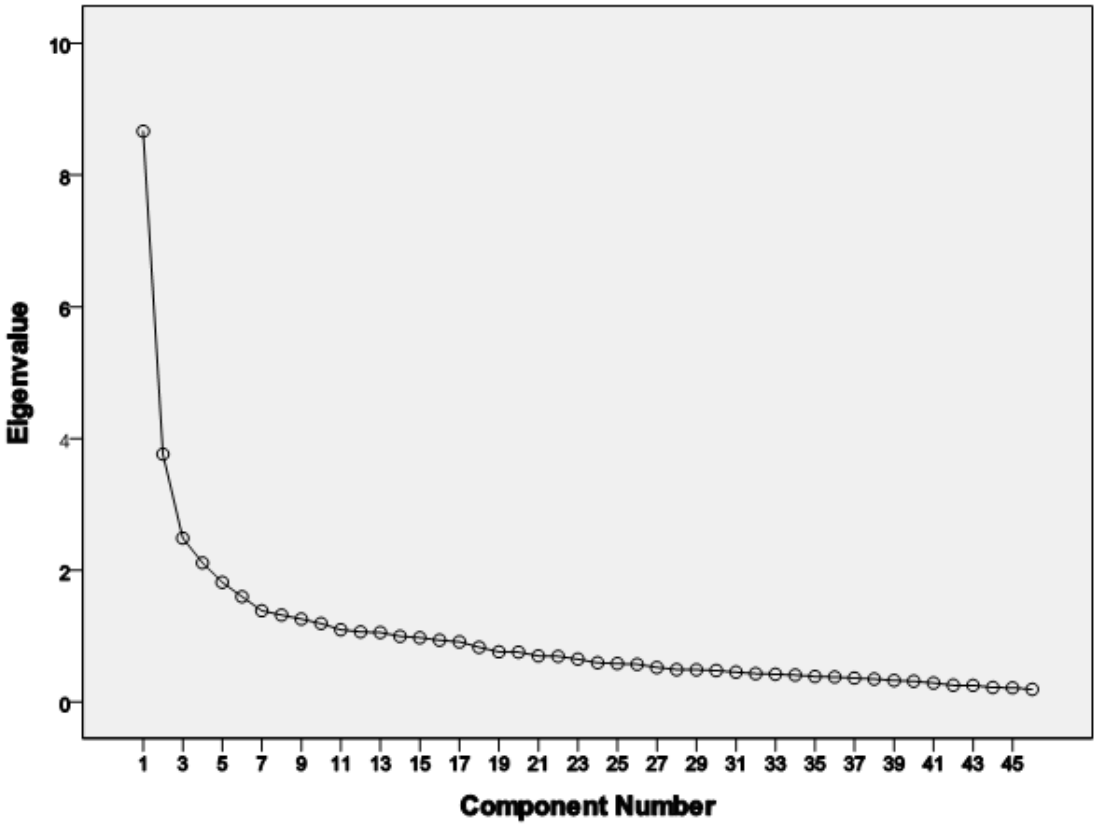

Figure 1. Screeplot results from PCA EFA with no specific number of factors.

Parallel analysis was carried out. Parallel analysis (Horn, 1965; as cited in Pallant, 2011) suggested there was only one component, as only one eigenvalue was larger than the corresponding randomly generated data matrix of the same size (46 variables x 269 respondents). Authors have noted that a 'general' factor is the result of the unrotated solution (Kline, 1994; Nunnally & Burnstein, 1994; as cited in Pett, Lackey, & Sullivan, 2003).

In summary, the above considerations lead to the conclusion that it was most appropriate to extract seven factors. The study further explores these initial factors next relying on factor rotation to improve the meaningfulness and interpretation of the seven extracted factors.

Factor Rotation and Interpretation

The seven initial factors were rotated to help the interpretation. The oblique rotation method was used. The oblique rotation method performed the direct oblimin rotation (Jennrich & Sampson, 1966; as cited in Pett, Lackey & Sullivan, 2003) and provided two matrices of loadings; the Structure Matrix (see Table 4) and the Pattern Matrix (see Apprendix J). There are different views in the literature dictating whether the focus should be on the structure matrix or the pattern matrix when evaluating and refining the factors. Pett, Lackey and Sullivan (2003) suggest that the focus should firstly be on the factor structure matrix when interpreting the factors and that this can then be compared with what is seen in the pattern matrix, at a later stage once decisions have been reached.

The ideal would be that the matrices reveal a simple structure (Thurstone, 1947; as cited in Pallant, 2011), with the seven factors showing items each loading strongly on a single factor. But, as Pett, Lackey and Sullivan (2003) explain, this is often not the case, and, items will sometimes display weak loadings on all factors or will have moderate to high loadings on multiple factors. Inspection of the structure matrix and pattern matrix, showed a relatively clear pattern of strong factor loadings (see Table 4 for structure matrix and Appendix I for pattern matrix). For each of the seven factors there were items with factor loadings greater than .40 loading onto them, thus fulfilling the suggested criteria enough to be considered significant (Hair et al, 1995). In

addition an examination of the communalities revealed that all items were above .30 (see Table 4), hence no items needed to be removed from the scale. Overall, the analyses suggested that the first factor comprised items with content relating to Incompetence/Inadequacy. Next, the second factor represented items containing references to Mistrust. The third factor comprised items measuring Demanding Standards, whilst, the fourth comprised items carrying content conceptualizing Sensitive/Rejection schema. The fifth represented items with content relating to Judgmental content, and the sixth factor represented items with content pertaining to Enmeshment. Lastly, the seventh factor contained items representing themes around Self-sacrifice.

Table 4

Structure Matrix for PCA with Oblimin Rotation of Seven Factor Solution of TSQ Items

Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7	Communalities
Tsq33	**.794**	.268	.082	-.080	.157	-.166	.063	.728
Tsq35	**.761**	.148	.187	-.059	.232	-.144	.172	.722
Tsq34	**.679**	-.115	.268	-.226	.381	-.308	.294	.729
Tsq36	**.629**	.318	-.026	-.139	.319	-.187	.259	.557
Tsq38	**.564**	.366	.074	-.358	.118	-.070	.171	.564
Tsq32	**.515**	.001	.146	-.378	.412	-.328	.114	.636
Tsq46	**.514**	.021	.128	-.293	.286	-.492	.245	.611
Tsq15	**.431**	.361	.042	-.025	.093	.037	.324	.642
Tsq24	.288	.152	.092	-.240	.263	-.172	.167	.768
Tsq8	.155	**.728**	-.004	.090	.243	-.049	-.176	.724
Tsq37	.374	**.663**	.046	-.165	-.006	-.378	.007	.669
Tsq22	.101	**.631**	-.080	-.210	.240	-.115	-.100	.652
Tsq14	.358	**.626**	.139	-.130	.309	-.280	.116	.620
Tsq16	-.198	.365	.328	-.102	.074	-.285	-.141	.681
Tsq3	.118	.036	**.771**	-.218	.051	-.245	.219	.683
Tsq4	.193	-.132	**.686**	-.103	.166	-.161	.163	.680
Tsq2	.151	.019	**.645**	-.098	.212	.090	.176	.675
Tsq1	.150	.085	**.601**	-.016	-.034	-.361	.240	.586
Tsq7	-.125	-.217	**.587**	.059	.184	-.195	.262	.569
Tsq6	.176	.298	**.586**	-.159	-.074	-.284	.232	.557
Tsq18	.104	.165	**.528**	-.267	.324	-.351	.240	.565
Tsq5	-.087	.057	.343	-.161	.051	-.002	.095	.745
Tsq20	.082	-.033	.228	**-.694**	.173	-.179	.180	.616
Tsq19	-.001	.003	.274	**-.586**	.163	-.078	.118	.701

(continued)

Table 4

Structure Matrix for PCA with Oblimin Rotation of Seven Factor Solution of TSQ Items

Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7	Communalities
Tsq31	.270	.243	.072	**-.510**	.178	-.107	-.091	.584
Tsq30	.356	.197	.151	**-.451**	-.043	-.053	.342	.623
Tsq23	.152	.097	.162	-.186	**.652**	-.106	.243	.646
Tsq17	.188	.256	.127	-.036	**.649**	-.430	.034	.606
Tsq21	.274	.092	-.073	-.306	**.570**	-.273	.044	.529
Tsq9	.263	.160	.254	-.153	**.547**	-.139	.367	.568
Tsq12	.156	.252	.042	.030	**.493**	-.112	.415	.442
Tsq13	.197	.282	.167	.141	**.446**	-.145	.172	.545
Tsq11	.210	.039	.162	-.152	**.444**	.073	.260	.544
Tsq29	.043	.286	.231	.046	.133	**-.682**	.268	.594
Tsq45	.194	.039	.115	-.178	.184	**-.659**	.215	.619
Tsq39	.137	.115	.355	-.241	.195	**-.578**	-.067	.689
Tsq43	.177	.066	.228	.258	.266	**-.564**	.364	.606
Tsq44	.476	.279	.126	-.081	.134	**-.532**	.134	.623
Tsq10	.058	.109	.303	.209	.383	-.386	.285	.628
Tsq28	.137	-.002	.180	-.179	.316	-.217	**.686**	.615
Tsq40	.182	.118	.262	.060	.069	-.025	**.684**	.716
Tsq41	.158	-.133	.411	-.020	.169	-.209	**.679**	.695
Tsq25	.229	-.258	.230	-.168	.277	-.222	**.624**	.598
Tsq42	.192	-.250	.131	-.050	.189	-.126	**.597**	.549
Tsq27	-.123	-.090	.194	-.084	.200	-.202	**.521**	.579
Tsq26	.334	-.019	.350	.124	.292	-.289	**.493**	.531

Note. Major loadings for each item are bolded

Refining of the Factors

Further inspection of the structure matrix revealed the presence of high multiple loadings on Items TSQ 12, TSQ 17, TSQ 32, TSQ 38, TSQ 41, TSQ 44, and TSQ 46 (see Table 4). These multiple loadings were dealt with in the following repeated PCA analysis. In addition, some items did not load significantly onto any factor. These items had loadings less than .40, and on evaluation, they did not seem to uniquely contribute to the instrument. Hence, the solution to these weak loadings as suggested by Hair et al. (1995) was to drop them (Hair et al., 1995). Based on these guidelines, there were four items (items TSQ 5, TSQ 10, TSQ 16, and TSQ 24) that were removed from further investigation. It was then decided to explore the structure of the TSQ with these items removed.

A new PCA with Oblimin rotation for the seven factors was undertaken excluding the four eliminated items and simplifying the presentation by suppressing loadings less than .40, thus, enabling clearer viewing of the factor loading patterns. The results were then re- evaluated. This new rotation resulted in a 42-item scale. Inspection of the structure matrix showed all items loading significantly onto the seven factors, although, these factor loading patterns were slightly complicated due to eight of the items loading strongly, with cross-loading levels above .40, onto multiple factors (see Table 5). And, rather than dropping all of these items, in accordance with the suggestion by Hair et al. (1995), they were examined, and it was determined where best to place the item. Thus, as Pett, Lackey and Sullivan (2003) suggest, they were placed on the factor that they were most closely related to theoretically and conceptually (Pett, Lackey & Sullivan, 2003).

The resulting decisions made were as follows: Item TSQ 38 had multiple loadings on Factor 1 and Factor 4. It appears, however, that Item TSQ 38 ‘I feel like I’m wasting time’, fits better conceptually with the other items which load onto Factor

1 (Incompetence/inadequacy), than it does with items loading onto Factor 4 (Judgmental), thus the decision was made to place Item TSQ38 with Factor 1. Similarly, Item TSQ 46 'I can't be myself', fits conceptually with Factor 6 (Enmeshment) and Item TSQ 17 'Sometimes I wonder if I will lose myself in the relationship', with Factor 4 (sensitive/rejection). Further, Item TSQ 12 'It's upsetting when patients terminate' had multiple loadings on Factor 5 and Factor 7, and it was decided to place it with Factor 5 (Sensitive/rejection), as it conceptually suits this factor, rather than Factor 7 (Self-sacrifice). Next, Item TSQ 44 'I feel frustrated with this patient because I can't express the way I really feel' was placed appropriately with Factor 6 (Enmeshment), rather than with Factor 1 (Incompetence/Inadequacy). And, interestingly, when looking at Item TSQ 41 'I should make them feel better', it could be seen that even though the content area allowed it to remain with either of the two Factors 3 and 7, Item TSQ 41 was deemed to fit better theoretically with Factor 7 (Self-sacrifice) rather than Factor 3 (Demanding standards). In addition Item TSQ 41 had higher loadings on Factor 7, than seen of Factor 3.

Lastly, Item TSQ 26 'If the patient isn't happy with me, then it means I'm doing something wrong', didn't seem to fit with either Factor 3 (Demanding standards) or with Factor 7 (Self-sacrifice). And, Item TSQ 32 'I feel like I am withdrawing emotionally during the session', lacked conceptual identification with both factors 1 or 4, that it was cross loaded highly onto. Hence, Item TSQ 26 and Item TSQ 32 were dropped from the analysis as they didn't seem to fit theoretically or conceptually with the factors that they cross loaded highly onto. It was decided next to repeat this PCA analysis with the remaining 40 items, exploring once again the structure of TSQ with these two items removed.

Table 5

Structure Matrix for PCA with Oblimin Rotation of Seven Factor Solution of 42 TSQ Items, Displaying Results where Factor Loading is Greater than 0.4

Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
Tsq 33	**.813**						
Tsq 35	**.766**						
Tsq 34	**.703**						
Tsq 36	**.637**						
Tsq 38	**.554**			-.433			
Tsq 46	.541					**-.485**	
Tsq 32	**.539**			-.428			
Tsq 8		**.738**					
Tsq 37		**.678**					
Tsq 14		**.632**					
Tsq 22		**.612**					
Tsq 15		**.442**					
Tsq 3			**.788**				
Tsq 4			**.682**				
Tsq 1			**.648**				
Tsq 2			**.624**				
Tsq 7			**.597**				
Tsq 6			**.583**				
Tsq 18			**.551**				
Tsq 2				**-.688**			
Tsq 19				**-.580**			
Tsq 31				**-.549**			
Tsq30				**-.510**			
Tsq17					.645	**-.424**	
Tsq23					**.622**		
Tsq21					**.562**		
Tsq9					**.544**		
Tsq12					**.478**		.411
Tsq11					**.431**		
Tsq13					**.403**		
Tsq29						**-.678**	
Tsq45						**-.674**	
Tsq39						**-.543**	
Tsq43						**-.541**	
Tsq44	.474					**-.528**	
Tsq40							**.700**
Tsq41			.424				**.697**
Tsq28							**.686**
Tsq25							**.633**
Tsq42							**.621**
Tsq27							**.507**
Tsq26			.401				**.484**

Note. Underlined values indicate a multiple loading. Loadings highlighted in bold indicate the factor on which the item was placed.

Internal Consistency of the Identified Factors

Another PCA with Oblimin rotation for the 40 item TSQ scale seven factor solution was undertaken excluding the current two items TSQ 26 and TSQ 32 that were dropped, the four previous items that were dropped, and once again, simplifying the presentation by suppressing loadings less than .40. The results of this PCA rotation were then re- evaluated in more detail by undertaking an item analysis and assessing the internal consistency/reliability of each of the seven factors. Because this study does not have items that have been standardized or equal means and standard deviations, the un-standardized coefficient alpha is reported for each of the factors. And, to reiterate that the decisions were not solely based on the statistical findings but also on the understanding of how the items group together intuitively, rationally, and theoretically, as suggested by Pett, Lackey, & Sullivan (2003).

Factor 1, Factor 3, Factor 6, and Factor 7 all showed good internal consistency. Factor 1 (Incompetence/Inadequacy) had a Chronbach alpha coefficient of .801, Factor 3 (Demanding standards) was .781, Factor 6 (Enmeshment) was .726, and Factor 7 (Self-sacrifice) was .767. On the contrary, Factor 2, Factor 4, and Factor 5 contained lower values. Factor 2 (Mistrust) had a Chronbach alpha coefficient of .690, Factor 4 (Sensitive/rejection) was .690, and Factor 5 (Judgmental) was .420. Thus, these factors were further investigated.

Firstly the items on Factor 2 were looked at. Item TSQ 15 ‘my movements, feelings or what I say are limited’ had the lowest factor loadings and didn’t seem to fit conceptually with the other items grouped under Factor 2. Also whilst looking at what happened to the coefficient alpha if Item TSQ 15 was removed, it showed that the reliability increased from .690 to .722. Thus, it was decided to remove Item TSQ 15 from the scale as it did not seem to either contribute conceptually or statistically to the

mistrust factor. Next, Factor 4 was investigated. All of the items seemed to contribute substantially to the theme and concept of the Factor 4 (Sensive/rejection), so, even though the Chronbach alpha coefficient of .690 was lower and slightly under the .7 threshold for good reliability, it was still decided to keep all the items due to their individual contribution to the scale. Lastly the four items (TSQ 19, TSQ 20, TSQ 30, and TSQ 31) on Factor 5 were analysed. Item TSQ 30 'I want to withhold thoughts and feelings from the patient' and Item TSQ 31 'I don't want to give them what they want' did not seem to fit conceptually or theoretically with Factor 5 (Judgemental). Therefore, it was concluded to remove these two items from the scale and reassess the internal consistency of Factor 5. The new coefficient alpha generated after the two items were removed was .599. Thus, an increase from .420 to .599 was seen in Chronbach's coefficient alpha once the two items were deleted from the scale, and so it was decided to only retain Items TSQ 19 and TSQ 20 on Factor 5. In summary, three items were deleted (Items TSQ 15, TSQ 30, and TSQ 31) as they did not contribute considerably to the internal consistency of the extracted factors, leaving 37 of the initial 46 items for the final analysis. The final alpha coefficients for the seven factors appear in the parentheses on the diagonal in Table 6 (see Table 6).

Table 6

Means, Standard Deviations, Factor Correlations and Factor Alpha Coefficients for the Seven Generated Factors of the TSQ

Factor/Schema	F1	F2	F3	F4	F5	F6	F7
F1 -Incompetence/Inadequacy	(.80)						
F2 –Mistrust	.414	(.72)					
F3 -Demanding standards	.249	.103	(.78)				
F4 -Sensitive/Rejection	.461	.378	.274	(.69)			
F5 –Judgmental	.179	.068	.302	.239	(.60)		
F6 –Enmeshment	.459	.372	.410	.441	.193	(.73)	
F7 -Self-sacrifice	.287	-.075	.427	.401	.214	.366	(.77)
Total Scale (n = 37)							(.88)

Note. Reliability estimates appear in the parentheses on the diagonal

Final 37 Item Scale

The refined seven extracted factors were subject to a final PCA oblimin rotation, dropping in total nine items (5, 10, 15, 16, 24, 26, 30, 31, and 32). The structure matrix, (see Table 7) showed the results of this final rotation of the factors of the 37-item scale. Analysis of the structure matrix showed all items loaded significantly above .40 onto their respective factors, indicating good discrimination between the seven factors.

Table 7

Structure Matrix for PCA with Oblimin Rotation of Seven Factor Solution of 37 TSQ Items, Displaying Results where Factor Loading is Greater than 0.4

Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
Tsq33	**.817**						
Tsq35	**.769**						
Tsq34	**.695**						
Tsq36	**.667**						
Tsq38	**.617**						
Tsq46	.526					**-.514**	
Tsq8		**.735**					
Tsq37		**.699**					
Tsq14		**.626**					
Tsq22		**.612**					
Tsq3			**.784**				
Tsq4			**.695**				
Tsq2			**.642**				
Tsq1			**.634**				
Tsq7			**.614**				
Tsq6			**.559**				
Tsq18			**.528**				
Tsq17				**.646**			
Tsq23				**.630**			
Tsq21				**.593**			
Tsq12				**.520**			.404
Tsq13				**.505**			
Tsq9				**.457**			.425
Tsq11				**.413**			
Tsq20					**.742**		
Tsq19					**.720**		
Tsq29						**-.683**	
Tsq45						**-.665**	
Tsq43						**-.561**	
Tsq39						**-.539**	
Tsq44	.495					**-.537**	

(continued)

Table 7

Structure Matrix for PCA with Oblimin Rotation of Seven Factor Solution of 37 TSQ Items, Displaying Results where Factor Loading is Greater than 0.4

Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
Tsq40							**.719**
Tsq41			.439				**.697**
Tsq28							**.690**
Tsq25							**.636**
Tsq42							**.611**
Tsq27							**.539**

Note. Underlined values indicate a multiple loading. Loadings highlighted in bold indicate the factor on which the item was placed

These factor loading patterns were slightly complicated, again, due to five of the items (Items TSQ 9, TSQ 12, TSQ 41, TSQ 44 and TSQ 46) loading strongly, with cross-loading levels above .40, onto multiple factors. Thus, once again, rather than dropping these items, in accordance with the suggestion by Hair et al. (1995), they were examined, and it was determined where best to place the item.

The resulting decisions made were as follows: Item TSQ 9 had multiple loadings on Factor 4 and Factor 7. It appears, however, that Item TSQ 9 'Conflicts are upsetting', had a slightly higher loading (.457) and fits better conceptually with the other items which load onto Factor 4 (Sensitive/rejection), than it does with items loading onto Factor 7 (Self- sacrifice), thus the decision was made to place Item TSQ 9 with Factor 4. Similarly, Item TSQ 12 'It's upsetting when patients terminate' had multiple loadings on Factor 4 and Factor 7, and so it was decided to place it with Factor 4 (Sensitive/rejection), as it had a higher loading of .520 and conceptually suits this factor, compared to Factor 7 (Self- sacrifice). Further, and interestingly as explained in

the previous refining of the factors (see section 3.10), even though the content area of Item TSQ 41 'I should make them feel better' allowed it to remain with either of the two Factors 3 and 7, Item TSQ 41 deemed to fit better theoretically with Factor 7 (Self -sacrifice) rather than Factor 3 (Demanding standards). In addition Item TSQ 41 loaded more strongly, having a higher loading of .697 on Factor 7, than the lower loading of .439 seen on Factor 3. Next, Item TSQ 44 'I feel frustrated with this patient because I can't express the way I really feel' was placed appropriately with Factor 6 (Enmeshment), rather than with Factor 1 (Incompetence/Inadequacy) as it had slightly higher loadings and thematically fits better with Factor 6, compared with Factor 1. Lastly, Item TSQ 46 'I can't be myself', fits conceptually and intuitively with Factor 6 (Enmeshment) rather than Factor 1 (Incompetence/inadequacy), even though it loaded slightly higher on Factor 1. Thus, it was decided to place Item TSQ 46 with Factor 6.

Pearson's product moment correlations were calculated between the seven factors (see Table 6). The correlation results were investigated following the guidelines suggested by Cohen (1988) when interpreting the strength of the relationship between the factors (Cohen, 1988; as cited in Pallant, 2011). As expected, the results revealed that there were no large (r = .50 to 1.0) correlations, eleven medium strength (r= .30 to .49) correlations, and ten low strength (r= .10 to .29) correlations between the seven factors. This suggested that the factors were primarily independent with a little overlap in correlation, which is to be expected because, although these seven factors may be conceptually unique, to some extent, they are each slightly correlated dimensions of the overall therapist schema construct (Pett, Lackey & Sullivan, 2003). On a final note, there was a negative correlation of -.075 seen for one of the correlations (Mistrust and Self- sacrifice), where high scores on mistrust are associated with low scores on the

self- sacrifice and vice versa. Thus, as would be expected, one may be hesitant in expressing self-sacrifice if they lacked trust.

In summary, there was a newly specified seven factor structure containing 37 items out of the initial 46 items. A total of nine items had been dropped in this factor refining process. Table 6 presents the descriptive statistics, between-factor correlations, and alpha coefficients for the seven generated factors of the TSQ (see Table 6). The correlations between the factors ranged from .07 (for the two factors Mistrust and Judgmental) to .46 (for Incompetence/inadequacy and Sensitive/Rejection). The reliability estimates presented in parentheses on the diagonal of Table 6 ranged from .60 to .80 (see Table 6). This new TSQ 37 item scale had a Cronbach alpha value of .88 indicating good internal consistency.

The Final Seven Factors/schemas

Factor one contained the five items TSQ 33, TSQ 34, TSQ 35, TSQ 36, and TSQ 38 (see Table 8) with content pertaining to a belief that one is not capable of handling day to day responsibilities competently or adequately. All of the four items (TSQ 33, TSQ 34, TSQ 35 and TSQ 36) from the ‘helplessness’ Therapist Schema emerged onto this factor. In addition one item (TSQ 38) from the ‘goal inhibition’ Therapist Schema emerged (Leahy, 2001). This factor was labelled F1 -Incompetence/Inadequacy, and represented 20.16 % of the extracted variance for the seven factors (see Table 9).

Table 8

Identified Factor Structure with Corresponding Items, and Item Loadings

Factor/Schema Label	Corresponding Item	Loading
F1 -Incompetence/ Inadequacy	Tsq33. I feel I don't know what to do.	.82
	Tsq35. I wonder if I'm really competent.	.78
	Tsq34. I fear I'll make mistakes.	.70
	Tsq36. Sometimes I feel like giving up.	.67
	Tsq38. I feel like I'm wasting time.	.62
F2 – Mistrust	Tsq8. Patients try to humiliate me.	.74
	Tsq22. The patient is trying to get to me.	.61
	Tsq37. The patient is blocking me from achieving my goals.	.70
	Tsq14. I feel controlled by the patient.	.63
F3 – Demanding Standards	Tsq3. My patients should do an excellent job.	.78
	Tsq4. We should never waste time.	.70
	Tsq1. I have to cure all my patients.	.63
	Tsq2. I must always meet the highest standards.	.64
	Tsq7. I shouldn't feel bored when doing therapy.	.61
	Tsq6. My patients should appreciate all that I do for them.	.56
	Tsq18. I have to control my surroundings or the people around me.	.53
F4 - Sensitive/ Rejection	Tsq17. Sometimes I wonder if I will lose myself in the relationship.	.65
	Tsq23. I have to guard against being taken advantage of or hurt.	.63
	Tsq9. Conflicts are upsetting.	.46
	Tsq21. I often feel provoked.	.60
	Tsq12. It's upsetting when patients terminate.	.52
	Tsq11. If my patient is bothered with therapy he or she might leave.	.41
	Tsq13. I might end up with no patients.	.51
F5 - Judgmental	Tsq20. People should be punished if they do wrong things.	.74
	Tsq19. Some people are basically bad people.	.72

(continued)

Table 8

Identified Factor Structure with Corresponding Items, and Item Loadings

Factor/Schema Label	Corresponding Item	Loading
F6 - Enmeshment	Tsq29. We should get along – almost like friends.	-.68
	Tsq45. I find it hard to suppress my feelings.	-.67
	Tsq39. I should be able to achieve my goals in sessions without the patient's interference.	-.54
	Tsq43. I sometimes believe that I would do almost anything to meet their needs.	-.56
	Tsq44. I feel frustrated with this patient because I can't express the way I really feel.	-.54
	Tsq46. I can't be myself	-.51
F7 - Self-sacrifice	Tsq40. I should meet my patients' needs.	.72
	Tsq41. I should make them feel better.	.70
	Tsq28. It bothers me if I don't like the patient.	.69
	Tsq42. The patients' needs often take precedence over my needs.	.61
	Tsq25. I want to be liked by the patient.	.64
	Tsq27. It's important that I like the patient.	.54

Table 9

Total Variance Explained by the Seven Extracted Factors, with an Oblimin Rotation Method

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	8.66	18.83	18.83	7.46	20.16	20.16	4.40
2	3.76	8.18	27.01	3.54	9.56	29.72	2.94
3	2.49	5.41	32.42	2.22	5.99	35.71	4.03
4	2.11	4.59	37.01	1.80	4.87	40.58	3.31
5	1.82	3.95	40.96	1.69	4.57	45.15	2.32
6	1.60	3.48	44.43	1.50	4.06	49.21	3.36
7	1.39	3.01	47.44	1.28	3.45	52.65	4.05

Note. When components are correlated, sum of squared loadings cannot be added to obtain a total variance

The second factor contained the items TSQ 8, TSQ 14, TSQ 22 and TSQ 37 representing a theme of having a lack of trust with the expectation that others will humiliate, will get at, or will control. It was made up of a mix of four of Leahy's Therapist Schemas: Special superior person (TSQ 8), Autonomy (TSQ 14), Persecution (TSQ 22) and Goal Inhibition (TSQ 37). The factor was labelled F2-Mistrust, and represented 9.56% of the extracted variance for the seven factors.

The third factor was comprised of seven items. These items were TSQ 1, TSQ 2, TSQ 3, TSQ 4, TSQ 6, TSQ 7, and TSQ 18 and together represented beliefs around perfectionist high expectations that one must meet. It contained a mix of all the four items (TSQ 1, TSQ 2, TSQ 3, TSQ 4) from the 'Demanding Standards' Therapist Schema, two items (TSQ 6, TSQ 7) from the 'Special Superior Person' Therapist Schema, and one and only item (TSQ 18) from the 'Control' Therapist Schema (Leahy, 2001). The factor was labelled F3 – Demanding standards, and represented 5.99% of the total variance from the extracted factors.

The fourth factor contained the seven items TSQ 9, TSQ 11, TSQ 12, TSQ 13, TSQ 17, TSQ 21, and TSQ 23. These items had beliefs containing themes of sensitivity, rejection, and instability, and the fear that if the client leaves therapy then it would be seen as a personal rejection of the therapist. It contained a mix of items from four of Leahy's Therapist Schemas. All three items (TSQ 11, TSQ 12, and TSQ 13) emerged from the 'Abandonment' Therapist Schema, one item (TSQ 9) from the 'Rejection/Sensitive' Therapist Schema, two items TSQ 21 and TSQ 23 from the 'Persecution' Therapist Schema and one item (TSQ 17) from the 'Autonomy'

Therapist Schema. The factor was labelled F4 – Sensitive/Rejection, and represented 4.87% of the extracted variance for the seven factors.

The fifth factor that was extracted revealed items TSQ 19 and TSQ 20 containing judgmental beliefs. These items that emerged were the same two items TSQ 19 and TSQ 20 from the 'Judgmental' Therapist Schema (Leahy, 2001). Factor five was labelled F5 – Judgmental, and represented 4.57% of the total variance from the extracted factors.

Next, the sixth factor represented six items describing an enmeshment conceptualization of beliefs in which boundary issues between client and therapist are evident. These items were TSQ 29, TSQ 39, TSQ 43, TSQ 44, TSQ 45, and TSQ 46. This unique factor that emerged contained a mix of four of Leahy's (2001) Therapist Schemas. All three items (TSQ 44, TSQ 45, and TSQ 46) emerged from the 'Emotional inhibition' Therapist Schema, one item (TSQ 39) from the 'Goal inhibition' Therapist Schema, one item (TSQ 29) from the 'Need to like others' Therapist Schema and one item (TSQ 43) from the 'Excessive self-sacrifice' Therapist Schema. The factor was labelled F6 – Enmeshment, and represented 4.06% of the total variance from the extracted factors.

Lastly, the seventh factor contained six items representing therapist beliefs around the need to sacrifice one's own needs for the needs of others with an emphasis on the importance of both liking, and being liked by the other in this process. These items were TSQ 25, TSQ 27, TSQ 28, TSQ 40, TSQ 41, and TSQ 42. This factor was a mix of three of Leahy's (2001) Therapist Schemas. Three out of the four items (TSQ 40, TSQ 41, and TSQ 42) emerged from the 'Excessive self-sacrifice' Therapist Schema, two items (TSQ 27 and TSQ 28) from the 'Need to like others' Therapist

Schema and one item (TSQ 25) from the 'Need for approval' Therapist Schema. The factor was labelled F7 – Self- sacrifice, and represented 3.45 % of the extracted variance for the seven factors.

In summary, the results identified a factor structure consisting of seven factors. Four of the fifteen Therapist Schemas proposed by Leahy (2001) emerged as independent factors in the present sample. These were the 'Demanding Standards' Therapist Schema, the 'Rejection/sensitive' Therapist Schema, the 'Judgmental' Therapist Schema, and the 'Excessive self-sacrifice' Therapist Schema. Three additional factors were produced as independent factors. These were the 'Incompetence/Inadequacy' factor, the 'Mistrust' factor, and the 'Enmeshment' factor. Of the eleven Therapist Schemas proposed by Leahy (2001) which did not emerge from the analyses, ten of them merged into other factors which had similar conceptualization or which better described the retained items. And, the 'Withholding' Therapist Schema failed to show up or be spread across any factors.

The results showed that, although ten of the fifteen Therapist Schemas did not emerge as independent factors, they were subtly present by having merged into other factors. For example, the 'Special Superior Person' Therapist Schema didn't emerge as an independent factor in the sample, but was scattered amongst 'Demanding Standards' and 'Mistrust' factors. Similarly, the 'Abandonment' Therapist Schema didn't emerge, but rather showed up on the 'Sensitive/Rejection' factor. The 'Autonomy' Therapist Schema items loaded onto both the 'Mistrust' and 'Sensitive/Rejection' factors. And, the 'Control' Therapist Schema, loaded onto the 'Demanding Standards' factor.

Further, the 'Persecution' Therapist Schema failed to show up as an independent Therapist Schema, and was scattered amongst the 'Mistrust' and 'Sensitive/Rejection' factors. The 'Need for approval' Therapist Schema showed up onto the 'Self-

sacrifice' factor, and the 'Need to be liked' Therapist Schema was spread across the 'Self- sacrifice' and 'Enmeshment' factors. Interestingly, even though the 'Helplessness' Therapist schema failed to emerge as an independent factor, it was seen to load onto the 'Incompetence/Inadequacy' factor which better described its retained items. In addition, the 'Goal Inhibition' Therapist Schema which also did not emerge as an independent factor was scattered amongst 'Incompetence/Inadequacy', 'Mistrust' and 'Enmeshment' factors. Lastly, the 'Emotional Inhibition' Therapist Schema failed to emerge, rather, all three of its corresponding proposed items showed up on the 'Enmeshment' factor. On a final note, as mentioned previously, only one schema, the 'Withholding' Therapist Schema, did not surface at all, nor did it appear scattered across the other factors.

As already mentioned, there were three additional factors, each with a more unique clustered version of the therapist schemas proposed by Leahy (2001). The first was 'Incompetence/Inadequacy', made up of a combination of items from the 'Helplessness' Therapist Schema and the 'Goal Inhibition' schema; the second was 'Mistrust', comprised of a mix of 'Special superior person', 'Autonomy', 'Persecution' and 'Goal Inhibition' Therapist Schemas. The third was 'Enmeshment', containing a blend of 'Emotional inhibition', 'Goal inhibition', 'Need to like others', and the 'Excessive Self- sacrifice' Therapist Schemas.

The Most Commonly Identified Therapist Schemas

Descriptive Statistics including the mean and standard deviation of the total scores for each of the seven identified factors was computed (see Table 10). The most commonly identified Therapist Schemas that were seen in this study were firstly the 'Self-sacrifice' Therapist Schema and secondly the 'Demanding Standards' Therapist

Schema (see Table 10). Next was the 'Sensitive/Rejection' Therapist Schema, then 'Incompetence/Inadequacy' Therapist Schema, followed by the 'Enmeshment' Therapist Schema. The least commonly identified Therapist Schemas were the 'Mistrust' and the 'Judgmental' Therapist Schemas (see Table 10).

Table 10

Mean and Standard Deviation Total Factor Scores for the Seven Identified Factors/Schemas

Factor/Schema	*N*	Range	Min	Max	Mean	*SD*
F1 - Incompetence/Inadequacy	269	22	5	27	14.05	5.08
F2 – Mistrust	269	15	4	19	6.88	3.14
F3 - Demanding standards	269	33	7	40	21.18	6.48
F4 - Sensitive/Rejection	269	28	7	35	18.53	5.42
F5 – Judgmental	269	10	2	12	5.21	2.51
F6 – Enmeshment	269	22	6	28	11.62	4.58
F7 – Self-sacrifice	269	30	6	36	21.30	5.97

CHAPTER SEVEN: DISCUSSION

Summary of Aims and of the Findings

The primary goal of the present study was to investigate the psychometric properties of the TSQ by exploring the underlying factor structure, along with its reliability among a group of therapists. Returning to the five aims specified earlier for this study (see chapter 4, p. 69), it can be seen that the study explored the TSQ data in terms of investigating the underlying factor structure, factor reliability, scale reliability, patterns of correlations between factors, and mean factor scores. Several questions relating to these areas were raised and addressed further in this inquiry. The following discussion initially attends to the findings of the study comparing them with previous research observations. Next implications of the findings are considered, along with its limitations. Lastly, recommendations for further research are expressed and concluding ideas shared.

Underlying Factor Structure

Firstly, the study aimed to investigate whether or not the items of the TSQ cluster into separate groups of homogenous items (factors) that represent underlying Therapist Schema. In addition, if they did form these clusters, then the following questions were asked: How many factors emerged in the factor structure? And next, what is the interpretation of these factors?

The Exploratory factor analysis findings supported a seven factor structure. The results confirmed that the items did cluster into separate groups of homogenous items

that represented the underlying Therapist Schema. Past research from Leahy's (2001) clinical observations suggested a 15 factor/schema underlying structure for the TSQ. The findings of the study were not entirely consistent with this, but rather suggest a newly specified structure that emerged consisting of seven factors and containing 37 items out of the initial 46 items. However, there were some items which loaded onto factors other than the rationally derived schemas proposed by Leahy (2001), some items which had high cross-loadings onto other factors, and the seven factors accounted for only 47.44% of the variance. A total of nine items had been dropped in the factor refining process. Four were dropped, because they loaded poorly onto the seven factors, a further two were dropped from the analysis because they didn't seem to fit theoretically or conceptually with the factors that they cross loaded highly onto. And, the remaining three were dropped as they did not seem to contribute either conceptually or statistically to the internal consistency of the factors they loaded highly onto. In particular, all three of the items (TSQ 30, TSQ 31, and TSQ 32) from the 'withholding' Therapist Schema were the most troublesome and did not fit either theoretically, conceptually, or statistically with the factors that they cross loaded highly onto.

The first factor was labelled F1 -Incompetence/ Inadequacy (see Table 7 on page 97 & Appendix J) and contained items with content pertaining to a belief that one is not capable of handling day to day responsibilities competently or adequately. It was a mixture of all of the four items from the 'helplessness' Therapist Schema and one item from the 'goal inhibition' Therapist Schema (Leahy, 2001). Next, the second factor was labelled F2- Mistrust and contained the items representing a theme of having a lack of trust with the expectation that others will humiliate, get at, or control. It was made up of a mix of four of Leahy's Therapist Schemas. These four were the Special

superior person, Autonomy Persecution and Goal Inhibition Therapist Schemas. Further, the third factor was labelled F3 – Demanding Standards, and it contained a mix of all the items from the 'Demanding Standards' Therapist Schema. It also included items from the 'Special Superior Person' and the 'Control' Therapist Schemas (Leahy, 2001).

The fourth factor was labelled F4 – Sensitive/Rejection and contained items that had beliefs containing themes of sensitivity, rejection, and instability, and the fear that if the client leaves therapy then it would be seen as a personal rejection of the therapist. It contained a mix of items from four of Leahy's Therapist Schemas. These four were the 'Abandonment' Therapist Schema, the 'Rejection/Sensitive' Therapist Schema, the 'Persecution' Therapist Schema and the 'Autonomy' Therapist Schema. Further, the fifth factor was labelled F5 – Judgmental and revealed items containing judgmental beliefs. These items that emerged were the same two items from the 'Judgmental' Therapist Schema (Leahy, 2001).

In addition, the sixth factor was labelled F6 – Enmeshment and represented items describing an enmeshment conceptualization of beliefs in which boundary issues between client and therapist are evident. This factor contained a mix of four of Leahy's (2001) Therapist Schemas. These four were the 'Emotional inhibition' Therapist Schema, the 'Goal inhibition' Therapist Schema, the 'Need to like others' Therapist Schema, and the 'Excessive self-sacrifice' Therapist Schema.

Lastly, the seventh factor was labelled F7 – Self- sacrifice and contained items representing therapist beliefs around the need to sacrifice one's own needs for the needs of others with an emphasis on the importance of both liking, and being liked by the other in this process. This factor was a mix of three of Leahy's (2001) Therapist Schemas. The three Therapist Schemas were the 'Excessive self-sacrifice' Therapist

Schema, the ‘Need to like others’ Therapist Schema and the ‘Need for approval’ Therapist Schema.

In summary, the EFA revealed a seven factor structure. The underlying factor structure showed they were made up of considerably different items compared to how they were originally operationalized based on Leahy’s (2001) clinical observations of Therapist Schemas. Removal of the items with poor loadings, those that cross- loaded on other factors that they did not fit conceptually with, and those that did not contribute statistically to the internal consistency, all created a more refined, clear interpretation of the seven factor structure.

Comparison of Findings with Previous Research Observations

Secondly, the study aimed to more closely explore the factors (schemas) that emerged and to compare them with Leahy’s (2001) clinical observations of Therapist Schemas. The three following questions were asked: Which of the 15 schemas that Leahy suggest, emerge? Are any of the independent schemas a combination of Leahy’s schemas merged together? Do any additional schemas emerge?

The findings from this study revealed that four of the fifteen Therapist Schemas originally proposed by Leahy emerged as independent factors in the present sample. These were the ‘Demanding Standards’ Therapist Schema, the ‘Rejection/sensitive’ Therapist Schema, the ‘Judgmental’ Therapist Schema, and the ‘Excessive self-sacrifice’ Therapist Schema. Of the eleven Therapist Schemas proposed by Leahy which did not emerge from the analyses, ten of them merged into other factors which had similar conceptualization or which better described the retained items (see final 37 item scale, Table 8, p. 102). And, the ‘Withholding’ Therapist Schema failed to show up or be spread across any factors. Three additional factors were produced as

independent factors. These were the 'Incompetence/Inadequacy' factor, the 'Mistrust' factor, and the 'Enmeshment' factor.

The finding that four of the fifteen Therapist Schemas originally proposed by Leahy (2001) emerged as independent factors in the present sample is now discussed and compared with previous research. Firstly, the 'F3- Demanding Standards' Therapist Schema contained all four of Leahy's 'Demanding Standards' items. Although, its conceptualization represents an interesting refinement of the previously proposed 'Demanding Standards' Therapist Schema, that was comprised mainly of perfectionist qualities. Findings suggest that it may have been tapping concepts of entitlement, with the addition of items from the 'special, superior person' Therapist Schema. Also, it may capture more of a control tone suggested with its addition of the 'control' Therapist Schema. This finding is also similar to Young's (1990) 'Unrelenting standards' schema evident in the client population (see chapter 1, p.12 & Appendix G).

Secondly, the 'F4- Sensitive/Rejection' Therapist Schema matched Leahy's 'Rejection/Sensitive' Therapist Schema. It was relabelled Sensitive/Rejection rather than the original Rejection/Sensitive as its primary theme was once of being sensitive, although its conceptualization conveys additional connotations of instability, and fear of abandonment. This may have been aided with the mix of Leahy's 'Abandonment' schema. It is also similar with the 'Abandonment/Instability' schema under Young's (1990) 'disconnection and rejection' domain (see chapter 1, p.12 & Appendix G). Interestingly both Leahy (2001) and Young link rejection/sensitive and abandonment schema concepts together, and similarly this pattern surfaced in this study as well.

Next, the F5 'Judgmental' Therapist Schema was consistent with Leahy's Judgmental' Therapist Schema. And lastly, the F7 'Self- sacrifice' Therapist Schema

matched closely with Leahy's (2001) 'Excessive Self- sacrifice Therapist Schema. At the same time it may have been tapping concepts of the importance of liking the client, aided by the 'need to like others' Leahy Therapist Schema items loading highly onto it, and also 'being liked by the client'. This needing to be liked could be seen by the 'need for approval' items that loaded highly onto this therapist schema. This is also similar to and consistent with Young's (1990) theory, in which Young's 'other-directedness' domain contains the schemas of 'Self- sacrifice and Approval seeking/recognition seeking'. For example, Young explains in prior studies, that the 'Self-sacrifice' schema linked with the 'Approval seeking/recognition seeking' schema, is an excessive focus on the desires, feelings, and responses of others, at the expense of one's own needs – in order to gain love and approval. Hence, this could aid the understanding of how 'the need to be liked' and 'the need to like others' Therapist Schema items may represent aspects of 'Self-sacrifice' thus emerging clustered and grouped with the 'Self-sacrifice' schema.

The fact that none of the items from the 'Withholding' Therapist Schema emerged suggest that it should be considered as a conceptually distinct schema, compared to Therapist Schema.

The ten Therapist Schemas proposed by Leahy (2001) which did not emerge from the analyses, merged into other factors in conceptually meaningful ways (see chapter 6, p.100).

The three additional factors, 'Incompetence/Inadequacy', 'Mistrust', and the 'Enmeshment', whom emerged from the EFA are discussed in turn. Each tended to be a more specific version of factors proposed by Leahy and overall contained a unique contribution to the measure. The first, 'F1- Incompetence/Inadequacy', was comprised with the majority of items from the 'Helplessness' Therapist Schema. Interestingly,

when compared with Leahy's conceptualization it does not appear to be as extreme as the helplessness concept, and it expresses more of a belief that one is not capable of handling day to day tasks as therapist. This taps into the theory around it conveying Self-as- therapist rather than a sense of helplessness in general as is seen in the 'Helplessness' schema. In addition, it is also a unique schema as it doesn't seem to compare with Young's (1990) 'Dependence/Incompetence' schema either as it doesn't have the 'unable to handle life competently without the considerable help of others' aspect to it. Thus, there is no dependence seen as with Young's conceptualization. The unique contribution appears to express a self-as- therapist schema of 'Incompetence'.

The second additional factor was the 'F2-Mistrust' factor. When compared with Leahy's (2001) schema's it didn't appear to fit with the content of the schemas that it's items were comprised from (Special superior person, Autonomy, and Goal Inhibition). However, when compared with Young's (1990) Mistrust/Abuse schema, similarities could be seen. This study's findings suggest a consistency with Young's (1990) theory, in which the 'Disconnection/Rejection' asserts that there is the expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage of (Young, 1990). Thus it remained to stand alone as a unique contribution to the measure.

On a final note, the third independent unique factor that emerged was the 'F6-Enmeshment' factor. Its content didn't appear to represent Leahy's schemas from which its items originated from. However, this unique schema appeared to be similar to Young's 'Enmeshment' schema. For example, some of Young's (1990) items from its Enmeshment Schema are 'I often feel that I do not have a separate identity', 'I often feel as if my ...are living through me- I don't have a life of my own', and 'I have trouble keeping any separate sense of myself' (Young, 1990).

Reliability

Thirdly, the study aimed to evaluate the reliability of, firstly, the final refined schemas that emerged and secondly, the reliability of the final refined TSQ scale. Further, these questions were asked: Do the items of each factor/schema that emerged show good internal consistency? And secondly, does the final refined TSQ measure as a whole show good internal consistency?

Factors 1, 2, 3, 6 and 7 all showed good internal consistency (see chapter 6, Table 6, p.96). Factor 1 (F1-Incompetence/Inadequacy) had a Chronbach alpha coefficient of .80, Factor 2 (F2- Mistrust) was .72, Factor 3 (F3-Demanding standards) was .78, Factor 6 (F6-Enmeshment) was .73, and Factor 7 (F7-Self- sacrifice) was .77. Two of the factors, Factor 4 and Factor 5 contained lower coefficient alphas. Factor 4 (F4-Sensitive/Rejection) had a Chronbach alpha coefficient of .69, Factor 5 (F5-Judgemental) was .60. So even though the Chronbach alpha coefficients of Factor 4 and Factor 5 were lower and slightly under the .7 threshold for good reliability, it was still decided to keep all the items due to their individual contribution to the scale.

The new TSQ 37 item scale had a Chronbach alpha value of .88 indicating good internal consistency.

Factor Correlations

Fourthly, the study investigated the correlations /strength of the relationships between the refined factors/schemas. As assumed, the results supported that the factors were clearly distinguishable constructs as there was only a small correlation between the seven factors (see chapter 6, Table 6, p.96). And this little overlap was to be

expected because the factors, although each unique and independent, were at the same time part of the overall Therapist Schema construct.

The patterns of correlations were all significant and in the expected directions, with the factors all being positively correlated with the exception of the 'F2-Mistrust' factor being negatively related to the 'F7-Self-sacrifice' factor. This suggested that participants who had high scores on the mistrust Therapist Schema would also have low scores on the self-sacrifice Therapist Schema. Similarly, this suggested that participants who had high scores on self-sacrifice Therapist Schema would also have low scores on the mistrust Therapist Schema. Therefore, as would be expected, people may be hesitant in expressing self-sacrifice if they lacked trust, and similarly, people tend to trust those whom they display self-sacrifice with.

Most Commonly Identified Therapist Schemas

The final aim was to look into what were the most commonly identified Therapist Schemas seen in the therapist sample. Firstly, the three most commonly identified Therapist Schemas that were seen in this study are discussed and secondly, they are compared with the more common Therapist Schemas that Haarhoff (2006) found to emerge. In addition, a comparison with theoretical themes from Young (1994) and Haarhoff are discussed.

The most commonly identified Therapist Schemas that were revealed in this study were firstly the 'Self-sacrifice' Therapist Schema, secondly the 'Demanding Standards' Therapist Schema (see chapter 6, Table 10, p.107), and thirdly the 'Sensitive/Rejection' Therapist Schema. These three most commonly identified Therapist Schemas had the highest means in the study (see Table 10, p.107).

The three most commonly identified Therapist Schemas reflect similar findings seen in the clinical observations and findings from Haarhoff (2006) (see chapter 4, p.

65). Two out of three of Haarhoff's most commonly identified Therapist Schemas surfaced again in this study. These two were the 'Self-sacrifice' Therapist Schema, similar to Haarhoff's 'Excessive Self-sacrifice' schema and the 'Demanding standards' Therapist Schema.

When compared with theoretical themes from Young (1994), the three most commonly identified Therapist Schemas come under three separate domains from Young. 'Self-sacrifice' is under the 'Other directedness' Domain IV. 'Demanding Standards' is similar to 'Unrelenting standards' and comes under the 'Overvigilance and Inhibition' Domain V. And the 'Sensitive/Rejection' Therapist Schema is similar to the 'Abandonment/Instability' schema, which comes under the 'Disconnection and Rejection' Domain I.

The slightly less commonly identified Therapist Schemas that emerged were the 'Incompetence/Inadequacy' Therapist Schema, followed by the 'Enmeshment' Therapist Schema. The least commonly identified Therapist Schemas were the 'Mistrust' and the 'Judgmental' Therapist Schemas. It was a reassuring to see that the 'Mistrust' and 'Judgmental' Therapist Schemas were the least commonly identified Therapist Schemas. It would be expected not to see a high appearance of common Therapist Schema pertaining to 'Judgmental' or 'Mistrust' as these schemas would have a negative effect on the therapeutic relationship. Although, a judgmental or mistrusting schema would still be beneficial to identify, if evident in the therapist, so the therapist can be aware of and work on these schemas to avoid impacting interpersonal processes in a detrimental way. For instance, the importance of the therapist being compassionate, non-judgmental, and empathetic is seen as important in providing the necessary context in the therapeutic relationship for change, thus contributing to successful outcome (Gilbert, 2007).

Implications

The findings of this study demonstrate the TSQ, in its present state, has good internal consistency reliability and the identified seven factor structure, 37 item scale is a good measurement that allows for the identification of a range of Therapist Schema.

The newly specified seven factor structure showed that the factors were made up of a different arrangement of items (see chapter 6, Table 8, p.102) compared to how they were grouped in the Leahy's (2001) original TSQ 46, 15 subscale questionnaire (see Appendix F). Four of the 15 originally proposed schemas emerged, and three additional schemas emerged. The 'Withholding' Therapist Schema was the only proposed Therapist Schema which did not emerge at all. The three additional factors that emerged that were not proposed by Leahy, F1-Incompetence/Inadequacy, F2-Mistrust, and F6-Enmeshment, each represent a more refined and uniquely theoretically meaningful combination of the original schema factors. Thus, EFA refining of the factors in this study, assisted to establish factor independence, allowing it to be a more thorough and reliable measure. The scale more clearly measures the Therapist Schema that it intends to measure, hence establishing the beginning of its 'construct validity'.

In addition, the study's results are reassuring for therapists or supervisors wanting the convenience of a shorter measure which would be quicker to administer. The TSQ short version of 37 items showed very similar levels of internal consistency to the TSQ original longer version of 46 items despite its more limited range of items.

Also, the finding of the three additional factors, 'F1-Incompetence/Inadequacy, F2- Mistrust, and F6-Enmeshment, that emerged in the study, conceptually extend the

original measure. These findings extend the measure with their unique contribution to the measure and have potential to provide more effective identification of clearer schema conceptualization for therapists. For instance, when working with personality traits and complex inter relational issues within the therapeutic relationship, the usefulness of identifying potential beliefs pertaining to enmeshment content, as evident in the additional independent F6-Enmeshment Therapist Schema that emerged in the study, would be beneficial. It would be vital to be aware of these beliefs and schemas when working with this client group, otherwise if unawares, this enmeshment schema could perpetuate unhealthy attachment inter relational cycles (Liotti, 2007). Hence, the studies' findings, provides a clearer interpretation of Therapist Schema, which will prove beneficial for therapists future practice.

The development of the TSQ measure, by the EFA establishing its reliability and underlying factor structure in this study, enables it to have increased significance and usefulness in practice. As mentioned above, its utility can be seen with its practical shorter 37 item version, also, in being able to target specific new schema such as F6-Enmeshment which may interfere with working in the interpersonal domain with clients.

On a final note, the shorter version TSQ37 is more specific than the original version in targeting certain Therapist Schema. For instance, the TSQ37 targets seven schemas rather than 15 schemas, which represent the underlying Therapist Schema construct. Hence, the refined version is more precise in its grouping of assumptions that represent overall Therapist schema, and thus, more useful for therapists to target specific Therapist Schema and the associated assumptions.

Limitations

Some limitations of this study are acknowledged. A general limitation of the TSQ is that the measure is vulnerable to weaknesses common to all self-report questionnaires, such as individual differences in how the same items are interpreted, the effect of therapist' affective state on responses, and the influence of expectations or impression management efforts by therapists.

Another limitation seen with just using a self-report measure for identifying the Therapist Schema construct is, like any test, that the TSQ provides just 'one way' to facilitate the therapists understanding of their belief system and therapist schema as triggered within the therapeutic relationship. Segal (1988) commented that self-reports can identify and name self-schema, but there are other ways, such as the Stroop information processing task, to assess schemas (Segal & Vella, 1990). More specifically, in the therapist and trainee population, Bennett-Levy and Thwaites (2007) describe other ways of identifying schema, such as SP/SR and the DPR model, and other ways mentioned in chapter four, such as the SQ (see chapter 4, p.57), which could also be used, as complementary techniques to test such schema information against, in addition to the data obtained from the TSQ, thus supporting the construct validity of the TSQ. For instance, the therapist could also fill out the dysfunctional attitudes scale (DAS), or they could mindfully observe the therapeutic relationship itself and reflect on the impasse moments (Katzow & Safran, 2007). Thus, if similarities and patterns of schema are seen between the TSQ identified schema combined with other information, such as commonly arising schema in the therapeutic relationship context with problem moments or within the interpersonal arena with clients, then the TSQ may increase in its potential trustworthiness.

A further limitation could be that the original TSQ may be tapping into other constructs other than just Therapist Schema. This is suggested from the finding that

the ‘withholding’ therapist schema did not emerge in the study, neither were its items scattered across other schemas. Nine items were dropped from the original 46 item scale as they did not contribute theoretically or conceptually to the measure. This also could suggest that the original TSQ may have been tapping into other constructs.

Future Directions

The TSQ is at its initial stages of development. The choice of exploratory PCA as a data-analytic strategy was chosen for this study because TSQ psychometrics had not been developed. In the future, confirmatory factor analysis (CFA) would be beneficial to validate the accuracy of the seven identified underlying factor structure that emerged in this study. In addition, the fact that none of the items from the ‘withholding’ Therapist Schema emerged suggest that it should be considered as a conceptually distinct schema, compared to Therapist Schema. It would be recommended that future research look to see if the ‘withholding’ therapist schema emerges in the CFA. Also, future exploring of the TSQ’s construct validity and other types of validity studies, would be advantageous.

Future directions could include, comparative research, for example to explore the hypothesis that the findings could be related to the therapists’ developmental stage may be useful (Haarhoff, 2006). Future directions could include correlation analyses to enable the exploration of relationships between the TSQ factors, for instance, those Therapist Schemas seen in a trainee/novice group of therapists, compared with the TSQ schemas evident within a group of experienced therapists. Also, future directions could compare results from a group of experienced therapists with a group of supervisors. Further, the therapists’ modality used, could be explored. For example, therapists practicing in a psychodynamic modality could be compared with CBT therapists,

exploring the hypothesis that having a psychodynamic background may reveal less extreme counter transference Therapist Schema, as they may be more experienced with working with these therapeutic interpersonal processes.

Conclusions

EFA was undertaken to determine the underlying factor structure and the reliability of the TSQ in this sample of therapists. The results of this study supported an underlying seven factor structure and a refined 37 item TSQ scale that demonstrated good internal consistency. Four of Leahy's (2001) original schemas emerged and three additional independent schemas emerged which were a combination of 10 of the original schemas. One original schema, the 'Withholding' Therapist Schema failed to emerge altogether in this study. Investigation of the factor correlations provided evidence of factor independence, and descriptive factor means revealed the three most commonly identified Therapist Schemas to be F7-Self- sacrifice, F3-Demanding standards, and F4-Sensitive/Rejection.

This study provided the initial psychometric evaluation of the TSQ and is at its beginning stages. Removal of items that had either poor loadings, or those that failed to contribute theoretically, conceptually, or statistically to those factors that they cross loaded highly onto, altogether, created a more robust measure. The altered measure, TSQ 37, demonstrated a better fitting measure than the original 47 item TSQ, interpreting more clearly Therapist Schema. The Therapist Schema questionnaire may be a more creditable measure to be utilized amongst therapists to facilitate the therapists' increase in self-awareness and to identify therapist beliefs and schema that may affect the therapy processes and the therapeutic relationship. It has potential use as a practical tool, to increase therapist insight, to assist in the therapists' self-practice

and self-reflection processes, to inform therapy interventions, and to utilize in the training and supervision of cognitive behavioural therapists. While further research is needed, the findings suggest that the TSQ has promise as a good measure of Therapist Schema and associated beliefs.

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Appendix A

Information Sheet for Participants

Evaluating the Psychometric Properties of a Therapist Schema Questionnaire (Leahy, 2001)

INFORMATION SHEET

Researcher: Rebekah Phin (BAHonsPGDipCBT). I am conducting this study as part of my Masters Degree at Massey University. The study will attempt to increase our understanding of therapists' contribution to the therapeutic relationship.

The purpose of the study is to investigate the psychometric properties of a measure identifying "therapist schema" (underlying beliefs about self as a therapist which could affect therapy). The measure shows potential use in on-going clinical practice, supervision, and in training, to assist therapists' uncover beliefs that may affect the course of therapy.

If you choose to participate in this research project, it will require you to complete the 'Leahy's Therapist Schema Questionnaire'. The questionnaire asks about your belief in 46 common therapists' assumptions about self-as-therapist. Time required to complete the questionnaire should not exceed 5-10 minutes. The questionnaire is anonymous so that you will not be able to be identified should you take part in the study. Please return the completed questionnaire in the enclosed self-addressed and pre-paid envelope.

Completion and return of the questionnaire implies consent. You have the right to decline to answer any particular question.

My supervisors for this research are Drs Bev Haarhoff and Mei Williams from the School of Psychology, Massey University, Albany.

If you have any questions about the project that you wish to discuss please do not hesitate to contact me, Rebekah Phin through my supervisor Bev Haarhoff, by email at B.A.Haarhoff@massey.ac.nz, or by telephone on 09-4140800, extn 41223.

If you are interested in receiving feedback from the research then you can contact me at the above address and a summary of the findings will be sent to you.

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O'Neill, Director, Research Ethics, telephone 06 3505249, email humanethics@massey.ac.nz.

Appendix B

Demographic Information Page

THERAPIST'S SCHEMA QUESTIONNAIRE (LEAHY, 2001)

Some brief demographic information

Age: _____

Gender:

Female ☐ Male ☐

Professional discipline:

Psychologist ☐ Counsellor ☐

Psychotherapist ☐ Nurse ☐

Social Worker ☐ Occupational Therapist ☐

Psychiatrist ☐ Other (Please state which one) ☐

Years of experience: _____

Work sector: Private ☐ Public ☐

Approximate number of hours spent doing client face to face therapy per week: _____

Main model of psychotherapy used:

Cognitive Behavioural Therapy ☐ Interpersonal Psychotherapy ☐

Narrative Therapy ☐ Mindfulness Based/Contemplative ☐

Person Centered/ Rogerian ☐ Psychoanalysis ☐

Family Therapy ☐ Psychodynamic Therapy ☐

Systems Therapy ☐ Transactional Analysis ☐

Gestalt Therapy ☐ Integrative psychotherapy ☐

Other (Please state which one) ☐

Ethnicity: (You can tick more than one box that applies)

New Zealand/Pakeha ☐ Maori ☐

Pacific Island (Please state which one) ☐ Asian (Please state which one) ☐

Other European (Please state which one) ☐

Appendix C

Advertisement Requesting Research Participants

Request for research participants

Conceptualizing the therapists' contribution to the therapeutic relationship is an increasing focus in CBT. In this research project the psychometric properties of a measure identifying "therapist schema" (underlying beliefs about self as therapist which could affect therapy) are investigated. The measure shows potential as a user-friendly screen which could be used in ongoing clinical practice, supervision, and in training, to assist therapists' uncover beliefs affecting the course of therapy.

Participants are required to the complete an on-line version of the Therapist Schema Questionnaire (Leahy, 2001). This will involve using a 6-point rating scale to endorse the strength of your belief in 46 common therapists' assumptions about self-as-therapist. Time required should not exceed 5-10 minutes

If you would like to participate please contact Rebekah Phin, through supervisor email at B.A.Haarhoff@massey.ac.nz, or by telephone on 09-4140800, extn 41223

Rebekah is completing her MA through the School of Psychology at Massey University in Albany, Auckland. Her supervisor is Dr Bev Haarhoff.

Appendix D

Email Requesting Research Participants

To whom it may concern,

My name is Rebekah Phin (BAHons in Psychology, PGDipCBT). I am conducting a study as research for my Masters Degree in Psychology at Massey University. My supervisors for this research are Drs Bev Haarhoff and Mei Williams from the School of Psychology, Massey University.

The purpose of the study is to investigate the psychometric properties of Leahy's (2001) Therapists' Schema Questionnaire (TSQ). The TSQ is a useful screening measure to identify therapist schema which could affect the therapeutic relationship.

This study involves each therapist briefly completing the Therapists' Schema questionnaire anonymously online for approximately 5 to 10min.

I am inquiring into the process of using your mailing list/data base of psychologists/therapists/counselors to use in this study. I would also be interested to put an advertisement in your next newsletter if possible. I look forward to hearing back from you soon.

Kind regards,

Rebekah Phin

Appendix E

Therapist's Schema Questionnaire: Leahy's (2001) 46-Item

Instructions: Listed below are assumptions that a person might use to describe themselves as a therapist. Please think about your current clients you are seeing for therapy. For each assumption below, circle the number to the right in the "rating scale" to indicate the degree of your belief in the assumption. There are no right or wrong answers. Try to avoid giving answers that you think are desirable.

	Rating Scale					
Assumptions	Very untrue	Somewhat Untrue	Slightly untrue	Slightly true	Somewhat true	Very true
1. I have to cure all my patients.	1	2	3	4	5	6
2. I must always meet the highest standards.	1	2	3	4	5	6
3. My patients should do an excellent job.	1	2	3	4	5	6
4. We should never waste time.	1	2	3	4	5	6
5. I am entitled to be successful.	1	2	3	4	5	6
6. My patients should appreciate all that I do for them	1	2	3	4	5	6
7. I shouldn't feel bored when doing therapy.	1	2	3	4	5	6
8. Patients try to humiliate me.	1	2	3	4	5	6
9. Conflicts are upsetting.	1	2	3	4	5	6
10. I shouldn't raise issues that will bother the patient.	1	2	3	4	5	6
11. If my patient is bothered with therapy he or she might leave.	1	2	3	4	5	6
12. It's upsetting when patients terminate.	1	2	3	4	5	6
13. I might end up with no patients.	1	2	3	4	5	6
14. I feel controlled by the patient.	1	2	3	4	5	6
15. My movements, feelings, or what I say are limited.	1	2	3	4	5	6
16. I should be able to do and say what I wish.	1	2	3	4	5	6
17. Sometimes I wonder if I will lose myself in the relationship.	1	2	3	4	5	6
18. I have to control my surroundings or the people around me.	1	2	3	4	5	6
19. Some people are basically bad people.	1	2	3	4	5	6
20. People should be punished if they do wrong things.	1	2	3	4	5	6
21. I often feel provoked.	1	2	3	4	5	6

22. The patient is trying to get to me.	1	2	3	4	5	6
23. I have to guard against being taken advantage of or hurt.	1	2	3	4	5	6
24. You usually can't trust people.	1	2	3	4	5	6
25. I want to be liked by the patient.	1	2	3	4	5	6
26. If the patient isn't happy with me, then it means I'm doing something wrong.	1	2	3	4	5	6
27. It's important that I like the patient.	1	2	3	4	5	6
28. It bothers me if I don't like the patient.	1	2	3	4	5	6
29. We should get along – almost like friends.	1	2	3	4	5	6
30. I want to withhold thoughts and feelings from the patient.	1	2	3	4	5	6
31. I don't want to give them what they want.	1	2	3	4	5	6
32. I feel I am withdrawing emotionally during the session.	1	2	3	4	5	6
33. I feel I don't know what to do.	1	2	3	4	5	6
34. I fear I'll make mistakes.	1	2	3	4	5	6
35. I wonder if I'm really competent.	1	2	3	4	5	6
36. Sometimes I feel like giving up.	1	2	3	4	5	6
37. The patient is blocking me from achieving my goals.	1	2	3	4	5	6
38. I feel like I'm wasting time.	1	2	3	4	5	6
39. I should be able to achieve my goals in sessions without the patient's interference.	1	2	3	4	5	6
40. I should meet the patients' needs.	1	2	3	4	5	6
41. I should make them feel better.	1	2	3	4	5	6
42. The patients' needs often take precedence over my needs.	1	2	3	4	5	6
43. I sometimes believe that I would do almost anything to meet their needs.	1	2	3	4	5	6
44. I feel frustrated with this patient because I can't express the way I really feel.	1	2	3	4	5	6
45. I find it hard to suppress my feelings.	1	2	3	4	5	6
46. I can't be myself.	1	2	3	4	5	6

Appendix F

Therapist's Schema Questionnaire: Leahy's (2001) Guide

Schema	Assumptions
Demanding standards	1. I have to cure all my patients.
	2. I must always meet the highest standards.
	3. My patients should do an excellent job.
	4. We should never waste time.
Special, superior person	5. I am entitled to be successful.
	6. My patients should appreciate all that I do for them
	7. I shouldn't feel bored when doing therapy.
	8. Patients try to humiliate me.
Rejection-sensitive	9. Conflicts are upsetting.
	10. I shouldn't raise issues that will bother the patient.
Abandonment	11. If my patient is bothered with therapy he or she might leave.
	12. It's upsetting when patients terminate.
	13. I might end up with no patients.
Autonomy	14. I feel controlled by the patient.
	15. My movements, feelings, or what I say are limited.
	16. I should be able to do and say what I wish.
	17. Sometimes I wonder if I will lose myself in the relationship.
Control	18. I have to control my surroundings or the people around me.
Judgmental	19. Some people are basically bad people.
	20. People should be punished if they do wrong things.
Persecution	21. I often feel provoked.
	22. The patient is trying to get to me.
	23. I have to guard against being taken advantage of or hurt.
	24. You usually can't trust people.
Need for approval	25. I want to be liked by the patient.
	26. If the patient isn't happy with me, then it means I'm doing something wrong.
Need to like others	27. It's important that I like the patient.
	28. It bothers me if I don't like the patient.
	29. We should get along – almost like friends.
Withholding	30. I want to withhold thoughts and feelings from the patient.
	31. I don't want to give them what they want.
	32. I feel I am withdrawing emotionally during the session.
Helplessness	33. I feel I don't know what to do.
	34. I fear I'll make mistakes.
	35. I wonder if I'm really competent.
	36. Sometimes I feel like giving up.
Goal inhibition	37. The patient is blocking me from achieving my goals.
	38. I feel like I'm wasting time.
	39. I should be able to achieve my goals in sessions without the patient's interference.
Excessive	40. I should meet the patients' needs.
self-sacrifice	41. I should make them feel better.
	42. The patients' needs often take precedence over my needs.
	43. I sometimes believe that I would do almost anything to meet their needs.
Emotional inhibition	44. I feel frustrated with this patient because I can't express the way I really feel.
	45. I find it hard to suppress my feelings.
	46. I can't be myself.

Appendix G

Early Maladaptive Schemas with Associated Schema Domains (Young, Klosko, & Weishaar, 2003)

Domain	Early Maladaptive Schema
Domain I – Disconnection and Rejection	1. Abandonment/Instability
	2. Mistrust/Abuse
	3. Emotional Deprivation
	4. Defectiveness/Shame
	5. Social Isolation/Alienation
Domain II- Impaired Autonomy and Performance	6. Dependence/Incompetence
	7. Vulnerability to Harm or Illness
	8. Enmeshment/Undeveloped Self
	9. Failure
Domain III – Impaired Limits	10. Entitlement/Grandiosity
	11. Insufficient Self-Control/Self-Discipline
Domain IV – Other-Directedness	12. Subjugation
	13. Self-Sacrifice
	14. Approval-Seeking/Recognition-Seeking
Domain V- Overvigilance and Inhibition	15. Negativity/Pessimism
	16. Emotional Inhibition
	17. Unrelenting Standards/Hypercriticalness
	18. Punitiveness

Appendix H

Correlation Matrix: 46-Item Therapist Schema Questionnaire (TSQ)

Item	**Tsq1**	**Tsq2**	**Tsq3**	**Tsq4**	**Tsq5**	**Tsq6**	**Tsq7**	**Tsq8**	
tsq1	**1.000**	**.266**	**.510**	**.298**	**.038**	**.399**	**.272**	**.051**	
tsq2	**.266**	**1.000**	**.409**	**.426**	**.213**	**.196**	**.295**	**.038**	
tsq3	**.510**	**.409**	**1.000**	**.430**	**.187**	**.492**	**.402**	**.002**	
tsq4	**.298**	**.426**	**.430**	**1.000**	**.169**	**.265**	**.435**	**-.140**	
tsq5	**.038**	**.213**	**.187**	**.169**	**1.000**	**.206**	**.154**	**-.077**	
tsq6	**.399**	**.196**	**.492**	**.265**	**.206**	**1.000**	**.176**	**.063**	
tsq7	**.272**	**.295**	**.402**	**.435**	**.154**	**.176**	**1.000**	**-.107**	
tsq8	**.051**	**.038**	**.002**	**-.140**	**-.077**	**.063**	**-.107**	**1.000**	
tsq9	**.176**	**.202**	**.203**	**.140**	**.094**	**.143**	**.123**	**.198**	
tsq10	**.250**	**.083**	**.150**	**.253**	**.001**	**.188**	**.249**	**.050**	
tsq11	**.063**	**.148**	**.095**	**.165**	**-.048**	**.046**	**.059**	**.091**	
tsq12	**.050**	**.102**	**.042**	**.013**	**.085**	**.095**	**.031**	**.156**	
tsq13	**.076**	**.155**	**.097**	**.130**	**-.021**	**.056**	**.079**	**.167**	
tsq14	**.100**	**.091**	**.137**	**.053**	**.124**	**.251**	**-.057**	**.383**	
tsq15	**.031**	**.008**	**.114**	**.077**	**-.009**	**.172**	**-.008**	**.230**	
tsq16	**.101**	**.168**	**.173**	**.145**	**.163**	**.217**	**.080**	**.226**	
tsq17	**.061**	**.033**	**.097**	**.092**	**.020**	**.129**	**.056**	**.349**	
tsq18	**.318**	**.240**	**.421**	**.212**	**.139**	**.397**	**.287**	**.068**	
tsq19	**.192**	**.151**	**.274**	**.212**	**-.029**	**.122**	**.078**	**-.028**	
tsq20	**.138**	**.113**	**.190**	**.162**	**.150**	**.129**	**.096**	**-.132**	
tsq21	**.005**	**.044**	**.037**	**.034**	**.055**	**.000**	**-.041**	**.071**	
tsq22	**.019**	**.013**	**-.086**	**-.068**	**-.030**	**.062**	**-.119**	**.430**	

tsq23	**.067**	**.145**	**.117**	**.109**	**.111**	**.071**	**.185**	**.124**	
tsq24	**.056**	**.078**	**.129**	**.128**	**-.059**	**.108**	**.044**	**.086**	
tsq25	**.181**	**.172**	**.229**	**.157**	**.075**	**.211**	**.288**	**-.239**	
tsq26	**.284**	**.220**	**.259**	**.259**	**.079**	**.244**	**.188**	**-.058**	
tsq27	**.163**	**.152**	**.151**	**.199**	**.092**	**.111**	**.224**	**-.190**	
tsq28	**.121**	**.174**	**.164**	**.224**	**.056**	**.136**	**.196**	**-.121**	
tsq29	**.252**	**.052**	**.181**	**.117**	**.084**	**.232**	**.185**	**.110**	
tsq30	**.141**	**.187**	**.206**	**.127**	**.023**	**.182**	**-.024**	**.010**	
tsq31	**.011**	**.091**	**.090**	**.070**	**.022**	**.168**	**-.050**	**.170**	
tsq32	**.065**	**.080**	**.210**	**.232**	**.034**	**.108**	**.068**	**.067**	
tsq33	**.101**	**.101**	**.063**	**.156**	**-.019**	**.198**	**-.139**	**.178**	
tsq34	**.244**	**.257**	**.235**	**.241**	**.050**	**.189**	**.146**	**-.009**	
tsq35	**.181**	**.186**	**.145**	**.206**	**.023**	**.220**	**-.027**	**.133**	
tsq36	**.132**	**.083**	**.056**	**.052**	**-.032**	**.097**	**-.111**	**.194**	
tsq37	**.176**	**-.049**	**.102**	**.016**	**.026**	**.267**	**-.087**	**.439**	
tsq38	**.055**	**.080**	**.079**	**.155**	**.011**	**.206**	**-.028**	**.185**	
tsq39	**.253**	**.079**	**.273**	**.305**	**.096**	**.291**	**.073**	**.048**	
tsq40	**.186**	**.172**	**.194**	**.134**	**.126**	**.192**	**.147**	**.014**	
tsq41	**.311**	**.235**	**.294**	**.313**	**.125**	**.224**	**.305**	**-.150**	
tsq42	**.130**	**.123**	**.137**	**.178**	**.025**	**.105**	**.229**	**-.151**	
tsq43	**.285**	**.070**	**.167**	**.194**	**-.073**	**.182**	**.221**	**.064**	
tsq44	**.225**	**.151**	**.127**	**.168**	**-.034**	**.158**	**.060**	**.178**	
tsq45	**.170**	**.038**	**.219**	**.092**	**.062**	**.181**	**.132**	**.079**	
tsq46	**.212**	**.110**	**.225**	**.164**	**.089**	**.116**	**.117**	**.050**	

Item	**Tsq9**	**Tsq10**	**Tsq11**	**Tsq12**	**Tsq13**	**Tsq14**	**Tsq15**	**Tsq16**		
tsq1	**.176**	**.250**	**.063**	**.050**	**.076**	**.100**	**.031**	**.101**		
tsq2	**.202**	**.083**	**.148**	**.102**	**.155**	**.091**	**.008**	**.168**		
tsq3	**.203**	**.150**	**.095**	**.042**	**.097**	**.137**	**.114**	**.173**		
tsq4	**.140**	**.253**	**.165**	**.013**	**.130**	**.053**	**.077**	**.145**		
tsq5	**.094**	**.001**	**-.048**	**.085**	**-.021**	**.124**	**-.009**	**.163**		
tsq6	**.143**	**.188**	**.046**	**.095**	**.056**	**.251**	**.172**	**.217**		
tsq7	**.123**	**.249**	**.059**	**.031**	**.079**	**-.057**	**-.008**	**.080**		
tsq8	**.198**	**.050**	**.091**	**.156**	**.167**	**.383**	**.230**	**.226**		
tsq9	**1.000**	**.267**	**.310**	**.328**	**.131**	**.300**	**.179**	**.052**		
tsq10	**.267**	**1.000**	**.181**	**.223**	**.272**	**.123**	**.070**	**.088**		
tsq11	**.310**	**.181**	**1.000**	**.190**	**.146**	**.145**	**.146**	**.035**		
tsq12	**.328**	**.223**	**.190**	**1.000**	**.309**	**.216**	**.190**	**.019**		
tsq13	**.131**	**.272**	**.146**	**.309**	**1.000**	**.231**	**.172**	**.063**		
tsq14	**.300**	**.123**	**.145**	**.216**	**.231**	**1.000**	**.304**	**.199**		
tsq15	**.179**	**.070**	**.146**	**.190**	**.172**	**.304**	**1.000**	**-.167**		
tsq16	**.052**	**.088**	**.035**	**.019**	**.063**	**.199**	**-.167**	**1.000**		
tsq17	**.268**	**.253**	**.135**	**.265**	**.300**	**.353**	**.082**	**.144**		
tsq18	**.271**	**.199**	**.116**	**.174**	**.184**	**.271**	**.142**	**.160**		
tsq19	**.218**	**-.041**	**.147**	**.024**	**.050**	**.065**	**.056**	**-.031**		
tsq20	**.184**	**.030**	**.167**	**.072**	**.002**	**.092**	**.024**	**.096**		
tsq21	**.246**	**.119**	**.179**	**.217**	**.173**	**.257**	**.083**	**-.022**		
tsq22	**.062**	**.046**	**.052**	**.108**	**.163**	**.347**	**.080**	**.212**		
tsq23	**.282**	**.243**	**.192**	**.245**	**.204**	**.211**	**.150**	**.013**		
tsq24	**.145**	**.136**	**.072**	**.182**	**.032**	**.142**	**.195**	**.094**		
tsq25	**.308**	**.136**	**.249**	**.239**	**.090**	**.061**	**.037**	**-.080**		

tsq26	**.270**	**.347**	**.179**	**.242**	**.261**	**.182**	**.139**	**-.076**		
tsq27	**.161**	**.152**	**.138**	**.174**	**.029**	**.074**	**.070**	**.023**		
tsq28	**.346**	**.245**	**.184**	**.266**	**.168**	**.169**	**.178**	**.030**		
tsq29	**.171**	**.296**	**.036**	**.188**	**.186**	**.242**	**.095**	**.263**		
tsq30	**.074**	**.068**	**.145**	**.136**	**.104**	**.157**	**.221**	**.026**		
tsq31	**.103**	**-.020**	**.074**	**.071**	**.121**	**.163**	**-.014**	**.129**		
tsq32	**.310**	**.197**	**.145**	**.085**	**.170**	**.238**	**.200**	**.020**		
tsq33	**.193**	**.114**	**.120**	**.112**	**.161**	**.384**	**.277**	**.030**		
tsq34	**.392**	**.144**	**.220**	**.224**	**.116**	**.203**	**.185**	**-.064**		
tsq35	**.272**	**-.020**	**.217**	**.195**	**.163**	**.343**	**.265**	**-.038**		
tsq36	**.274**	**.100**	**.202**	**.264**	**.218**	**.332**	**.257**	**-.002**		
tsq37	**.147**	**.145**	**-.034**	**.098**	**.171**	**.453**	**.270**	**.104**		
tsq38	**.189**	**.115**	**.169**	**.113**	**.133**	**.306**	**.260**	**.004**		
tsq39	**.129**	**.275**	**.118**	**.077**	**.145**	**.224**	**.039**	**.271**		
tsq40	**.239**	**.184**	**.137**	**.213**	**.137**	**.117**	**.191**	**.070**		
tsq41	**.238**	**.283**	**.176**	**.140**	**.134**	**-.009**	**.096**	**-.048**		
tsq42	**.158**	**.140**	**.135**	**.188**	**.098**	**-.017**	**.094**	**-.140**		
tsq43	**.202**	**.318**	**.061**	**.210**	**.193**	**.180**	**.115**	**.114**		
tsq44	**.131**	**.196**	**.043**	**.141**	**.237**	**.349**	**.177**	**.071**		
tsq45	**.232**	**.135**	**.088**	**.156**	**.057**	**.269**	**.031**	**.130**		
tsq46	**.234**	**.172**	**.179**	**.203**	**.182**	**.185**	**.254**	**.058**		

Item	Tsq17	Tsq18	Tsq19	Tsq20	Tsq21	Tsq22	Tsq23	Tsq24

tsq1	**.061**	**.318**	**.192**	**.138**	**.005**	**.019**	**.067**	**.056**
tsq2	**.033**	**.240**	**.151**	**.113**	**.044**	**.013**	**.145**	**.078**
tsq3	**.097**	**.421**	**.274**	**.190**	**.037**	**-.086**	**.117**	**.129**
tsq4	**.092**	**.212**	**.212**	**.162**	**.034**	**-.068**	**.109**	**.128**
tsq5	**.020**	**.139**	**-.029**	**.150**	**.055**	**-.030**	**.111**	**-.059**
tsq6	**.129**	**.397**	**.122**	**.129**	**.000**	**.062**	**.071**	**.108**
tsq7	**.056**	**.287**	**.078**	**.096**	**-.041**	**-.119**	**.185**	**.044**
tsq8	**.349**	**.068**	**-.028**	**-.132**	**.071**	**.430**	**.124**	**.086**
tsq9	**.268**	**.271**	**.218**	**.184**	**.246**	**.062**	**.282**	**.145**
tsq10	**.253**	**.199**	**-.041**	**.030**	**.119**	**.046**	**.243**	**.136**
tsq11	**.135**	**.116**	**.147**	**.167**	**.179**	**.052**	**.192**	**.072**
tsq12	**.265**	**.174**	**.024**	**.072**	**.217**	**.108**	**.245**	**.182**
tsq13	**.300**	**.184**	**.050**	**.002**	**.173**	**.163**	**.204**	**.032**
tsq14	**.353**	**.271**	**.065**	**.092**	**.257**	**.347**	**.211**	**.142**
tsq15	**.082**	**.142**	**.056**	**.024**	**.083**	**.080**	**.150**	**.195**
tsq16	**.144**	**.160**	**-.031**	**.096**	**-.022**	**.212**	**.013**	**.094**
tsq17	**1.000**	**.364**	**.085**	**.089**	**.322**	**.195**	**.323**	**.122**
tsq18	**.364**	**1.000**	**.297**	**.236**	**.152**	**.069**	**.254**	**.115**
tsq19	**.085**	**.297**	**1.000**	**.428**	**.107**	**.101**	**.133**	**.141**
tsq20	**.089**	**.236**	**.428**	**1.000**	**.155**	**.041**	**.219**	**.184**
tsq21	**.322**	**.152**	**.107**	**.155**	**1.000**	**.292**	**.367**	**.168**
tsq22	**.195**	**.069**	**.101**	**.041**	**.292**	**1.000**	**.162**	**.190**
tsq23	**.323**	**.254**	**.133**	**.219**	**.367**	**.162**	**1.000**	**.288**
tsq24	**.122**	**.115**	**.141**	**.184**	**.168**	**.190**	**.288**	**1.000**
tsq25	**.088**	**.305**	**.104**	**.176**	**.156**	**-.109**	**.198**	**.163**
tsq26	**.173**	**.280**	**.055**	**.093**	**.154**	**.001**	**.163**	**.248**

tsq27	**.154**	**.121**	**.143**	**.124**	**.051**	**-.035**	**.084**	**.069**
tsq28	**.159**	**.243**	**.164**	**.228**	**.145**	**.001**	**.211**	**.179**
tsq29	**.244**	**.273**	**.077**	**.106**	**.080**	**.177**	**.091**	**.160**
tsq30	**.005**	**.176**	**.154**	**.232**	**.117**	**.138**	**.053**	**.139**
tsq31	**.230**	**.144**	**.082**	**.216**	**.205**	**.237**	**.105**	**.159**
tsq32	**.352**	**.310**	**.169**	**.226**	**.294**	**.006**	**.323**	**.254**
tsq33	**.207**	**.108**	**-.009**	**.101**	**.183**	**.167**	**.111**	**.257**
tsq34	**.274**	**.257**	**.177**	**.264**	**.275**	**.039**	**.225**	**.235**
tsq35	**.230**	**.200**	**.079**	**.102**	**.175**	**.102**	**.151**	**.249**
tsq36	**.275**	**.089**	**.006**	**.115**	**.317**	**.256**	**.202**	**.202**
tsq37	**.152**	**.175**	**.065**	**.091**	**.171**	**.351**	**.072**	**.188**
tsq38	**.123**	**.097**	**.139**	**.170**	**.206**	**.250**	**.153**	**.192**
tsq39	**.274**	**.250**	**.162**	**.307**	**.218**	**.045**	**.087**	**.136**
tsq40	**.068**	**.168**	**.001**	**.105**	**-.054**	**-.103**	**.171**	**.089**
tsq41	**.122**	**.267**	**.089**	**.181**	**.049**	**-.104**	**.262**	**.088**
tsq42	**.055**	**.091**	**.080**	**.090**	**.153**	**-.154**	**.225**	**.030**
tsq43	**.332**	**.208**	**-.003**	**-.004**	**.122**	**.030**	**.177**	**.171**
tsq44	**.223**	**.187**	**.047**	**.116**	**.254**	**.173**	**.169**	**.068**
tsq45	**.250**	**.224**	**.140**	**.106**	**.226**	**.064**	**.100**	**.126**
tsq46	**.286**	**.241**	**.055**	**.211**	**.292**	**.080**	**.226**	**.228**

Item	Tsq25	Tsq26	Tsq27	Tsq28	Tsq29	Tsq30	Tsq31	Tsq32

tsq1	**.181**	**.284**	**.163**	**.121**	**.252**	**.141**	**.011**	**.065**
tsq2	**.172**	**.220**	**.152**	**.174**	**.052**	**.187**	**.091**	**.080**
tsq3	**.229**	**.259**	**.151**	**.164**	**.181**	**.206**	**.090**	**.210**
tsq4	**.157**	**.259**	**.199**	**.224**	**.117**	**.127**	**.070**	**.232**
tsq5	**.075**	**.079**	**.092**	**.056**	**.084**	**.023**	**.022**	**.034**
tsq6	**.211**	**.244**	**.111**	**.136**	**.232**	**.182**	**.168**	**.108**
tsq7	**.288**	**.188**	**.224**	**.196**	**.185**	**-.024**	**-.050**	**.068**
tsq8	**-.239**	**-.058**	**-.190**	**-.121**	**.110**	**.010**	**.170**	**.067**
tsq9	**.308**	**.270**	**.161**	**.346**	**.171**	**.074**	**.103**	**.310**
tsq10	**.136**	**.347**	**.152**	**.245**	**.296**	**.068**	**-.020**	**.197**
tsq11	**.249**	**.179**	**.138**	**.184**	**.036**	**.145**	**.074**	**.145**
tsq12	**.239**	**.242**	**.174**	**.266**	**.188**	**.136**	**.071**	**.085**
tsq13	**.090**	**.261**	**.029**	**.168**	**.186**	**.104**	**.121**	**.170**
tsq14	**.061**	**.182**	**.074**	**.169**	**.242**	**.157**	**.163**	**.238**
tsq15	**.037**	**.139**	**.070**	**.178**	**.095**	**.221**	**-.014**	**.200**
tsq16	**-.080**	**-.076**	**.023**	**.030**	**.263**	**.026**	**.129**	**.020**
tsq17	**.088**	**.173**	**.154**	**.159**	**.244**	**.005**	**.230**	**.352**
tsq18	**.305**	**.280**	**.121**	**.243**	**.273**	**.176**	**.144**	**.310**
tsq19	**.104**	**.055**	**.143**	**.164**	**.077**	**.154**	**.082**	**.169**
tsq20	**.176**	**.093**	**.124**	**.228**	**.106**	**.232**	**.216**	**.226**
tsq21	**.156**	**.154**	**.051**	**.145**	**.080**	**.117**	**.205**	**.294**
tsq22	**-.109**	**.001**	**-.035**	**.001**	**.177**	**.138**	**.237**	**.006**
tsq23	**.198**	**.163**	**.084**	**.211**	**.091**	**.053**	**.105**	**.323**
tsq24	**.163**	**.248**	**.069**	**.179**	**.160**	**.139**	**.159**	**.254**
tsq25	**1.000**	**.413**	**.325**	**.443**	**.137**	**.176**	**.029**	**.191**
tsq26	**.413**	**1.000**	**.242**	**.344**	**.280**	**.129**	**-.023**	**.124**

tsq27	**.325**	**.242**	**1.000**	**.484**	**.194**	**.042**	**-.046**	**.025**
tsq28	**.443**	**.344**	**.484**	**1.000**	**.215**	**.202**	**-.004**	**.218**
tsq29	**.137**	**.280**	**.194**	**.215**	**1.000**	**.087**	**.032**	**.138**
tsq30	**.176**	**.129**	**.042**	**.202**	**.087**	**1.000**	**.326**	**.245**
tsq31	**.029**	**-.023**	**-.046**	**-.004**	**.032**	**.326**	**1.000**	**.302**
tsq32	**.191**	**.124**	**.025**	**.218**	**.138**	**.245**	**.302**	**1.000**
tsq33	**.105**	**.233**	**-.067**	**.124**	**.123**	**.188**	**.193**	**.369**
tsq34	**.397**	**.413**	**.147**	**.237**	**.160**	**.222**	**.204**	**.460**
tsq35	**.188**	**.328**	**.002**	**.173**	**.132**	**.204**	**.127**	**.277**
tsq36	**.229**	**.224**	**.101**	**.207**	**.167**	**.202**	**.233**	**.338**
tsq37	**-.080**	**.089**	**-.059**	**.040**	**.286**	**.154**	**.233**	**.219**
tsq38	**.142**	**.098**	**-.019**	**.163**	**.039**	**.275**	**.298**	**.308**
tsq39	**.058**	**.153**	**.091**	**.027**	**.287**	**.055**	**.169**	**.208**
tsq40	**.263**	**.278**	**.169**	**.307**	**.159**	**.183**	**-.049**	**.126**
tsq41	**.416**	**.365**	**.224**	**.353**	**.226**	**.237**	**.027**	**.179**
tsq42	**.385**	**.213**	**.218**	**.315**	**.053**	**.181**	**.040**	**.191**
tsq43	**.231**	**.285**	**.223**	**.257**	**.439**	**.071**	**-.024**	**.139**
tsq44	**.119**	**.213**	**.007**	**.168**	**.324**	**.239**	**.134**	**.292**
tsq45	**.278**	**.237**	**.144**	**.210**	**.339**	**.072**	**.058**	**.262**
tsq46	**.307**	**.211**	**.049**	**.278**	**.276**	**.328**	**.225**	**.476**

Item	Tsq33	Tsq34	Tsq35	Tsq36	Tsq37	Tsq38	Tsq39	Tsq40
tsq1	**.101**	**.244**	**.181**	**.132**	**.176**	**.055**	**.253**	**.186**
tsq2	**.101**	**.257**	**.186**	**.083**	**-.049**	**.080**	**.079**	**.172**
tsq3	**.063**	**.235**	**.145**	**.056**	**.102**	**.079**	**.273**	**.194**
tsq4	**.156**	**.241**	**.206**	**.052**	**.016**	**.155**	**.305**	**.134**
tsq5	**-.019**	**.050**	**.023**	**-.032**	**.026**	**.011**	**.096**	**.126**
tsq6	**.198**	**.189**	**.220**	**.097**	**.267**	**.206**	**.291**	**.192**
tsq7	**-.139**	**.146**	**-.027**	**-.111**	**-.087**	**-.028**	**.073**	**.147**
tsq8	**.178**	**-.009**	**.133**	**.194**	**.439**	**.185**	**.048**	**.014**
tsq9	**.193**	**.392**	**.272**	**.274**	**.147**	**.189**	**.129**	**.239**
tsq10	**.114**	**.144**	**-.020**	**.100**	**.145**	**.115**	**.275**	**.184**
tsq11	**.120**	**.220**	**.217**	**.202**	**-.034**	**.169**	**.118**	**.137**
tsq12	**.112**	**.224**	**.195**	**.264**	**.098**	**.113**	**.077**	**.213**
tsq13	**.161**	**.116**	**.163**	**.218**	**.171**	**.133**	**.145**	**.137**
tsq14	**.384**	**.203**	**.343**	**.332**	**.453**	**.306**	**.224**	**.117**
tsq15	**.277**	**.185**	**.265**	**.257**	**.270**	**.260**	**.039**	**.191**
tsq16	**.030**	**-.064**	**-.038**	**-.002**	**.104**	**.004**	**.271**	**.070**
tsq17	**.207**	**.274**	**.230**	**.275**	**.152**	**.123**	**.274**	**.068**
tsq18	**.108**	**.257**	**.200**	**.089**	**.175**	**.097**	**.250**	**.168**
tsq19	**-.009**	**.177**	**.079**	**.006**	**.065**	**.139**	**.162**	**.001**
tsq20	**.101**	**.264**	**.102**	**.115**	**.091**	**.170**	**.307**	**.105**
tsq21	**.183**	**.275**	**.175**	**.317**	**.171**	**.206**	**.218**	**-.054**
tsq22	**.167**	**.039**	**.102**	**.256**	**.351**	**.250**	**.045**	**-.103**
tsq23	**.111**	**.225**	**.151**	**.202**	**.072**	**.153**	**.087**	**.171**
tsq24	**.257**	**.235**	**.249**	**.202**	**.188**	**.192**	**.136**	**.089**
tsq25	**.105**	**.397**	**.188**	**.229**	**-.080**	**.142**	**.058**	**.263**

tsq26	**.233**	**.413**	**.328**	**.224**	**.089**	**.098**	**.153**	**.278**
tsq27	**-.067**	**.147**	**.002**	**.101**	**-.059**	**-.019**	**.091**	**.169**
tsq28	**.124**	**.237**	**.173**	**.207**	**.040**	**.163**	**.027**	**.307**
tsq29	**.123**	**.160**	**.132**	**.167**	**.286**	**.039**	**.287**	**.159**
tsq30	**.188**	**.222**	**.204**	**.202**	**.154**	**.275**	**.055**	**.183**
tsq31	**.193**	**.204**	**.127**	**.233**	**.233**	**.298**	**.169**	**-.049**
tsq32	**.369**	**.460**	**.277**	**.338**	**.219**	**.308**	**.208**	**.126**
tsq33	**1.000**	**.519**	**.600**	**.462**	**.379**	**.414**	**.155**	**.114**
tsq34	**.519**	**1.000**	**.563**	**.389**	**.117**	**.299**	**.225**	**.166**
tsq35	**.600**	**.563**	**1.000**	**.445**	**.207**	**.328**	**.124**	**.152**
tsq36	**.462**	**.389**	**.445**	**1.000**	**.329**	**.420**	**.172**	**.211**
tsq37	**.379**	**.117**	**.207**	**.329**	**1.000**	**.390**	**.221**	**.029**
tsq38	**.414**	**.299**	**.328**	**.420**	**.390**	**1.000**	**.199**	**.174**
tsq39	**.155**	**.225**	**.124**	**.172**	**.221**	**.199**	**1.000**	**-.023**
tsq40	**.114**	**.166**	**.152**	**.211**	**.029**	**.174**	**-.023**	**1.000**
tsq41	**.076**	**.305**	**.099**	**.122**	**-.023**	**.108**	**.134**	**.575**
tsq42	**.044**	**.277**	**.130**	**.139**	**-.072**	**.074**	**.035**	**.393**
tsq43	**.146**	**.286**	**.244**	**.195**	**.134**	**.022**	**.240**	**.198**
tsq44	**.337**	**.275**	**.317**	**.344**	**.407**	**.315**	**.276**	**.116**
tsq45	**.092**	**.333**	**.199**	**.132**	**.248**	**.120**	**.281**	**.136**
tsq46	**.339**	**.448**	**.337**	**.308**	**.204**	**.246**	**.221**	**.145**

Item	Tsq41	Tsq42	Tsq43	Tsq44	Tsq45	Tsq46
tsq1	**.311**	**.130**	**.285**	**.225**	**.170**	**.212**
tsq2	**.235**	**.123**	**.070**	**.151**	**.038**	**.110**

tsq3	**.294**	**.137**	**.167**	**.127**	**.219**	**.225**
tsq4	**.313**	**.178**	**.194**	**.168**	**.092**	**.164**
tsq5	**.125**	**.025**	**-.073**	**-.034**	**.062**	**.089**
tsq6	**.224**	**.105**	**.182**	**.158**	**.181**	**.116**
tsq7	**.305**	**.229**	**.221**	**.060**	**.132**	**.117**
tsq8	**-.150**	**-.151**	**.064**	**.178**	**.079**	**.050**
tsq9	**.238**	**.158**	**.202**	**.131**	**.232**	**.234**
tsq10	**.283**	**.140**	**.318**	**.196**	**.135**	**.172**
tsq11	**.176**	**.135**	**.061**	**.043**	**.088**	**.179**
tsq12	**.140**	**.188**	**.210**	**.141**	**.156**	**.203**
tsq13	**.134**	**.098**	**.193**	**.237**	**.057**	**.182**
tsq14	**-.009**	**-.017**	**.180**	**.349**	**.269**	**.185**
tsq15	**.096**	**.094**	**.115**	**.177**	**.031**	**.254**
tsq16	**-.048**	**-.140**	**.114**	**.071**	**.130**	**.058**
tsq17	**.122**	**.055**	**.332**	**.223**	**.250**	**.286**
tsq18	**.267**	**.091**	**.208**	**.187**	**.224**	**.241**
tsq19	**.089**	**.080**	**-.003**	**.047**	**.140**	**.055**
tsq20	**.181**	**.090**	**-.004**	**.116**	**.106**	**.211**
tsq21	**.049**	**.153**	**.122**	**.254**	**.226**	**.292**
tsq22	**-.104**	**-.154**	**.030**	**.173**	**.064**	**.080**
tsq23	**.262**	**.225**	**.177**	**.169**	**.100**	**.226**
tsq24	**.088**	**.030**	**.171**	**.068**	**.126**	**.228**
tsq25	**.416**	**.385**	**.231**	**.119**	**.278**	**.307**
tsq26	**.365**	**.213**	**.285**	**.213**	**.237**	**.211**
tsq27	**.224**	**.218**	**.223**	**.007**	**.144**	**.049**
tsq28	**.353**	**.315**	**.257**	**.168**	**.210**	**.278**

tsq29	**.226**	**.053**	**.439**	**.324**	**.339**	**.276**
tsq30	**.237**	**.181**	**.071**	**.239**	**.072**	**.328**
tsq31	**.027**	**.040**	**-.024**	**.134**	**.058**	**.225**
tsq32	**.179**	**.191**	**.139**	**.292**	**.262**	**.476**
tsq33	**.076**	**.044**	**.146**	**.337**	**.092**	**.339**
tsq34	**.305**	**.277**	**.286**	**.275**	**.333**	**.448**
tsq35	**.099**	**.130**	**.244**	**.317**	**.199**	**.337**
tsq36	**.122**	**.139**	**.195**	**.344**	**.132**	**.308**
tsq37	**-.023**	**-.072**	**.134**	**.407**	**.248**	**.204**
tsq38	**.108**	**.074**	**.022**	**.315**	**.120**	**.246**
tsq39	**.134**	**.035**	**.240**	**.276**	**.281**	**.221**
tsq40	**.575**	**.393**	**.198**	**.116**	**.136**	**.145**
tsq41	**1.000**	**.457**	**.370**	**.145**	**.159**	**.199**
tsq42	**.457**	**1.000**	**.272**	**.083**	**.203**	**.206**
tsq43	**.370**	**.272**	**1.000**	**.279**	**.231**	**.191**
tsq44	**.145**	**.083**	**.279**	**1.000**	**.330**	**.429**
tsq45	**.159**	**.203**	**.231**	**.330**	**1.000**	**.443**
tsq46	**.199**	**.206**	**.191**	**.429**	**.443**	**1.000**

Appendix I

Pattern Matrix for PCA with Oblimin Rotation of Seven Factor Solution of TSQ Items

Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
Tsq33	**.793**	.121	.056	.054	.001	-.036	-.106
Tsq35	**.755**	.005	.151	.080	.078	.011	-.025
Tsq34	**.629**	-.278	.157	-.093	.214	-.154	.055
Tsq36	**.524**	.209	-.141	-.036	.166	-.056	.152
Tsq38	**.471**	.281	.000	-.275	-.042	.061	.094
Tsq32	**.426**	-.150	.031	-.275	.287	-.207	-.080
Tsq46	**.407**	-.118	-.036	-.198	.104	-.405	.086
Tsq15	.352	.334	-.021	.040	-.038	.157	.301
Tsq24	.186	.084	-.002	-.181	.166	-.077	.081
Tsq8	.058	**.702**	.011	.155	.225	.052	-.204
Tsq22	-.051	**.606**	-.136	-.177	.196	-.040	-.092
Tsq37	.249	**.597**	-.040	-.093	-.180	-.309	-.021
Tsq14	.193	**.555**	.041	-.034	.169	-.135	.029
Tsq16	-.297	.363	.312	-.075	.036	-.233	-.189
Tsq3	.058	-.011	**.741**	-.128	-.100	-.084	.034
Tsq4	.188	-.203	**.688**	-.002	.067	-.003	-.062
Tsq2	.129	-.015	**.679**	-.006	.150	.283	-.008
Tsq7	-.163	-.227	**.551**	.110	.131	-.095	.116
Tsq1	.103	.042	**.551**	.067	-.199	-.253	.098
Tsq6	.090	.269	**.534**	-.080	-.261	-.152	.125
Tsq18	-.049	.104	**.418**	-.183	.189	-.194	.079
Tsq5	-.140	.068	.335	-.142	.014	.077	.046
Tsq20	-.063	-.082	.098	**-.679**	.065	-.098	.115

Tsq19	-.122	-.025	.192	**-.573**	.092	.010	.057
Tsq31	.178	.164	.022	**-.464**	.104	-.024	-.168
Tsq30	.247	.166	.043	**-.414**	-.220	.046	.326
Tsq23	-.008	.032	.047	-.114	**.619**	.052	.106
Tsq17	.032	.148	.009	.060	**.599**	-.310	-.138
Tsq21	.135	-.019	-.202	-.243	**.529**	-.187	-.081
Tsq9	.102	.095	.127	-.064	**.452**	.040	.226
Tsq12	-.017	.232	-.099	.085	**.420**	.019	.365
Tsq11	.114	-.004	.098	-.091	**.410**	.220	.154
Tsq13	.093	.232	.107	.227	.397	-.011	.057
Tsq10	-.055	.065	.195	.286	.300	-.285	.158
Tsq29	-.120	.243	.055	.099	-.039	**-.646**	.210
Tsq45	.062	-.052	-.072	-.126	.021	**-.641**	.122
Tsq39	.047	.008	.267	-.164	.077	**-.517**	-.233
Tsq43	.073	.003	.078	.338	.124	**-.502**	.248
Tsq44	.388	.162	.004	.018	-.053	**-.463**	.011
Tsq40	.064	.149	.133	.101	-.093	.098	**.680**
Tsq28	-.056	-.009	-.035	-.145	.159	-.104	**.653**
Tsq41	.045	-.142	.256	.035	.000	-.085	**.593**
Tsq42	.107	-.267	-.021	-.021	.069	-.056	**.550**
Tsq25	.111	-.300	.049	-.122	.130	-.123	**.533**
Tsq27	-.272	-.062	.030	-.086	.108	-.146	**.519**
Tsq26	.252	-.083	.230	.223	.140	-.153	.343

Note. Major loadings for each item are bolded

Appendix J

Therapist's Schema Questionnaire: 37-Item (TSQ-37) with Identified Factor Structure and their Corresponding Assumptions Found Within this Study

Factor/Schema Label	Corresponding Assumptions
F1 -Incompetence/ Inadequacy	Tsq33. I feel I don't know what to do.
	Tsq35. I wonder if I'm really competent.
	Tsq34. I fear I'll make mistakes.
	Tsq36. Sometimes I feel like giving up.
	Tsq38. I feel like I'm wasting time.
F2 - Mistrust	Tsq8. Patients try to humiliate me.
	Tsq22. The patient is trying to get to me.
	Tsq37. The patient is blocking me from achieving my goals.
	Tsq14. I feel controlled by the patient.
F3 – Demanding standards	Tsq3. My patients should do an excellent job.
	Tsq4. We should never waste time.
	Tsq1. I have to cure all my patients.
	Tsq2. I must always meet the highest standards.
	Tsq7. I shouldn't feel bored when doing therapy.
	Tsq6. My patients should appreciate all that I do for them.
	Tsq18. I have to control my surroundings or the people around me.
F4 - Sensitive/ Rejection	Tsq17. Sometimes I wonder if I will lose myself in the relationship.
	Tsq23. I have to guard against being taken advantage of or hurt.
	Tsq9. Conflicts are upsetting.
	Tsq21. I often feel provoked.
	Tsq12. It's upsetting when patients terminate.
	Tsq11. If my patient is bothered with therapy he or she might leave.
	Tsq13. I might end up with no patients.
F5 - Judgmental	Tsq20. People should be punished if they do wrong things.
	Tsq19. Some people are basically bad people.
F6 - Enmeshment	Tsq29. We should get along – almost like friends.
	Tsq45. I find it hard to suppress my feelings.
	Tsq39. I should be able to achieve my goals in sessions without the patient's interference.
	Tsq43. I sometimes believe that I would do almost anything to meet their needs.
	Tsq44. I feel frustrated with this patient because I can't express the way I really feel.
	Tsq46. I can't be myself
F7 - Self sacrifice	Tsq40. I should meet my patients' needs.
	Tsq41. I should make them feel better.
	Tsq28. It bothers me if I don't like the patient.
	Tsq42. The patients' needs often take precedence over my needs.
	Tsq25. I want to be liked by the patient.
	Tsq27. It's important that I like the patient.