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Maladaptive therapist schemas in CBT practice, training and supervision: A scoping review

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Maladaptive therapist schemas in CBT practice, training and supervision: A scoping review

Background: Maladaptive therapist schemas are hypothesised to generate difficulties within cognitive behavioural therapy practice, training and supervision. Without adequate identification and management, they negatively affect the cognitions and emotions of the therapist, leading them to behave in ways that risk ruptures or therapy and supervision being delivered in a sub-optimal fashion. Consequently, there is a need to synthesise the research that has been undertaken to date on the content, prevalence, identification, and management of maladaptive therapist schemas.

Method: A scoping review was undertaken of studies that have been published since 2001 on the impact of maladaptive therapist schemas (also referred to interchangeably as beliefs or cognitions) in Cognitive behavioural therapy practice, training and supervision. Thirteen studies were identified in a literature search from four electronic databases, a reference list search of identified articles and hand searches.

Results: Three overall themes were identified in the research, (1) prevalence of therapist schemas (2) specific therapist beliefs and (3) therapist characteristics associated with the delivery of sub-optimal CBT or supervision. Whilst there is little empirical support for therapist schemas, therapist resistance and beliefs relating to the fear of using exposure therapy were identified. Therapist intolerance of uncertainty and self-esteem were recurrent factors.

Conclusion: There is no consensus on how to define, identify, formulate or respond to maladaptive therapist beliefs or schemas in clinical practice, training or

supervision. Further research is needed to better understand their origins, maintaining factors and appropriate management of their impact.

Key practitioner message

- The aim of this scoping review was to synthesise the existing research on the ways in which maladaptive therapist schemas impact CBT
- There is little consensus on how to identify, formulate or manage maladaptive therapist schemas in CBT practitioners
- Those involved in the training or supervision of CBT practitioners might look to incorporate some of the scales highlighted in the review within their work with students and supervisees.

Key words: CBT, supervision, training, schemas, drift, therapist beliefs

Introduction

Cognitive Behavioural Therapy (CBT) is an evidence-based, psychological treatment that is applied to a wide range of mental health problems across the world (Butler et al., 2006; Gratzer, 2020). For example, in the United Kingdom (UK), CBT is recommended as the first line intervention by the National Institute for Clinical Excellence, (NICE) for the treatment of OCD, BDD, GAD, Panic, SAD, PTSD, and Psychosis (NICE, 2005, 2009, 2011, 2013, 2018). CBT is an effective treatment when practitioners are able to develop a good working alliance with patients and deliver the interventions competently and with adherence to the evidence base (Butler et al., 2006; Gilbert & Leahy, 2010; Waller, 2009). It has been documented across all theoretical orientations that therapists own unresolved personal issues are highly likely to impact on their clinical work at some stage (Hayes et al., 2018). In relation to this, CBT theory would suggest that therapists and supervisors, like all human beings, sometimes experience unhelpful thoughts about themselves (e.g. doubting one's ability), their clients (e.g. believing the client is resisting change), the model (e.g. it does not work for complex clients) and supervision (e.g. the supervisor is trying to catch me out) (Beck et al., 1979; Katzow & Safran, 2010). Regardless of their level of experience or the quality of training provided, CBT therapists do not interact with clients or within supervisory relationships as blank slates, rather they bring into these relationships a mental map of the world that has been constructed based on prior experiences.

Moment to moment therapist reactions are underpinned by (often) implicit beliefs about oneself and the world (Beck, 1979). The terms 'core beliefs' and 'schemas' are often used interchangeably in the CBT literature to explain this yet can refer to very different concepts (see Figure 1) with unique theoretical underpinnings

(Davidson, 2008; James et al., 2013;Leahy, 2001; Young et al., 2006). Kennerely et al., (2017) state that 'there is agreement that a schema is more than a belief; it is an information processing structure that enables us to classify incoming information and to anticipate events. Some authors argue that it is a purely cognitive structure, whilst others argue that it is more complex and multi-modal" (p391). A detailed description of these theories is beyond the scope of this paper, however in short, schemas according to Young et al (2006) are likely to be broader than the schemas in Beck's cognitive therapy (James et al., 2013).

It has been hypothesised in the literature that numerous therapist factors such as their beliefs prior to training, their personal rules and assumptions about self and others and their use of safety seeking behaviours can impede skill acquisition, use of supervision and reduce their fidelity to the CBT model (Bennett-Levy, 2019; Haarhoff & Thwaites, 2016; Leahy, 2001; Milne, 2009; Roscoe, 2021b; Waller, 2009; Wilcockson,2022). It is therefore of increasing importance to better understand maladaptive CBT therapist schemas and the ways in which they impede training, supervision, and clinical practice.

Understanding how therapists get in their own way

Therapist and supervisory drift

Several studies have referred to poor laboratory to clinic room translation with lower recovery rates observed in the later and there are huge variations in patient outcomes between therapists (Bennett-Levy, 2019; Delgadillo et al., 2020; Simpson-Southward et al., 2018). Bennett-Levy (2019) points out that "the most effective 15–

20% of therapists achieve recovery rates at about twice the rate of the 15–20% of therapists at the bottom of the distribution, while the least effective therapists have deterioration rates at double the rate of the effective therapists" (p134). In other words, not every therapist who claims to practice CBT wins and not all of them deserve prizes (Heinonen & Nissen-Lie,2019). It has been suggested by some leading authors in the field that sub-optimal CBT is often characterised by therapist drift where therapists either intentionally or unintentionally substitute, avoid or delay key components of treatment, often exposure-based methods (Waller, 2009; Waller & Turner, 2016). The use of safety behaviours by therapists (e.g. delivering exposure cautiously or introducing anxiety management techniques when affect is high) is thought to prevent them from learning that feared outcomes are unlikely (Salkovskis, 1991). It is important to consider what is known about the psychological characteristics of therapists who may be more susceptible to therapy drift. A systematic review of correlations between therapist characteristics and therapist drift by Speer et al., (2022) found a range of factors including knowledge of evidence-based treatments, clinician attitudes towards research, anxiety, clinical experience, age, primary theoretical orientation, personality traits, cultural competence and capacity to engage in critical thinking. A related phenomenon, supervisory drift, has also been highlighted and has been hypothesised to occur when "core components of supervision (e.g., outcomes monitoring, direct observation, mutual feedback) are omitted, avoided or deprioritised" (Pugh & Margetts, 2020, p. 5). There is tentative support for this being commonplace in every day supervisory practices. For example Weck et al. (2017) found that the most widely used method in supervision was case discussion, limiting opportunities for more experiential learning methods. An earlier study by Townend et al. (2002) found that only 18% of BABCP accredited CBT

therapists shared therapy session recordings with their supervisor and Roscoe et al., (2022b) found that some supervisees withheld showing videos due to a fear of being exposed as incompetent.

Therapist rigidity or misconceptions

In contrast to omitting aspects of treatment, some therapists display extreme rigidity to models or protocols, refusing to show any flexibility with their formulations, sequencing of treatment or use of the therapeutic relationship (Whittington & Grey, 2014). This is potentially problematic as it can result in clients feeling invalidated, pushed into change too soon and to therapeutic ruptures or treatment attrition (Gilbert & Leahy, 2010; Katzow & Safran, 2010; Leahy, 2001). Therapist misconception of theory or interventions is also frequently reported. For example, Murray and colleagues (2022) describe ten common misconceptions about the application of trauma focused CBT for Post-traumatic stress disorder (e.g. that it is not suitable for multiple traumatic events). It is possible that these misconceptions arise during training and these beliefs about what treatment should and should not entail are not updated despite subsequent supervision and clinical exposure to traumatised clients.

Role transition difficulties during CBT training

There is little research on the experiences of role transition when mental health professionals (e.g. counsellors, nurses, social workers) embark on CBT training (Robinson et al., 2012; Wilcockson, 2020). Waltman and colleagues (2017) describe common pitfalls in CBT training within the United States, such as difficulties in

trainees examining their own thoughts about setting an agenda or homework in sessions. In the UK, Robinson et al., (2012) found that considerable support was needed in supervision to assist with the formation of a new professional identity. Elsewhere, Wilcockson (2022) highlights how post-qualification, person-centred counsellors do not practice CBT in accordance with the evidence base, instead adapting it to previous ways of working. Finally, Roscoe et al., (2022a) identified resistance to applying guided discovery amongst trainees suggesting that their previous professional 'self' competes with the emerging CBT 'therapist self' when exposed to new theories, interventions and clinical experiences.

Transference and counter-transference

Despite CBT historically downplaying the importance of paying specific and close attention to the therapeutic alliance, CBT practitioners are just as likely to become caught in transference and counter-transference issues with clients, supervisors or supervisees than those of other therapeutic orientations (Katzow & Safran, 2010; Leahy, 2001; Moorey & Byrne, 2019; Moorey & Lavender, 2019). Therapist reactions in clinical practice, training and supervision can impede their own skill development, relationships with clients and effectiveness as a clinician (Bennett-Levy, 2019; Milne et al., 2009; Wilcockson, 2020). For example, a dependent client may pull an excessive caregiving response from a therapist, reinforcing their sense of helplessness and interfering with the core aims of treatment. On occasions, some therapists may overstep boundaries by disclosing highly personal and inappropriate information to clients. Prasko et al., (2022) provides a range of examples of how these processes may present and be managed within clinical supervision.

Burnout and Vicarious trauma

Burnout characterised by emotional exhaustion is a known risk factor for mental health professionals (Kaeding et al., 2017; Simpson et al., 2019). Vicarious trauma is also an occupational hazard yet according to McLean and colleagues (2003) “It can be seen that therapist beliefs tended to be the sole or most important contributor to both burnout and VT [vicarious trauma] ” (p425). If certain beliefs predispose CBT practitioners to the a for mentioned difficulties it might be necessary to look more closely at the psychological characteristics of the person delivering therapy in order to improve therapist wellbeing and the standards of therapy, training and supervision.

Why therapists get in their own way

Unmanaged therapist schemas

Given the potential adverse impacts on CBT efficacy, it is important to better understand the types of beliefs that drive problems such as drift, inflexibility, burnout, transference and role transition resistance, their origins and maintaining factors. Leahy (2001) proposed the existence of fifteen therapist schemas, that differ from Young’s eighteen in that they are often unconditional, limited to the working life of the therapist and potentially more responsive to attempts at modification (Haarhoff, 2006). He developed the Therapist schema questionnaire as a means of identifying common beliefs that from his clinical experience, were associated with therapist led, therapy interfering behaviours. Whilst Leahy described these schemas occurring in relation to the practice of cognitive therapy, his therapist schemas appear to share more in common with those of Young. For example, a range of endorsed statements on the therapist schema questionnaire (TSQ) are indicative of a specific schema

(e.g. demanding standards) which resembles the EMS “Unrelenting standards / Hypercriticalness (Young et al.,2006).

Underemphasis in training and supervision?

Prominent CBT practitioners such as Beck (1995) and Bennett-Levy (2019) have signalled the importance of therapists identifying their own problematic cognitions including the development of structured self-practice / self-reflection programmes (Bennett-Levy et al., 2001; 2003). SP/SR has a growing evidence base and has been shown to improve CBT therapist technical, conceptual and interpersonal skills, empathy for clients and mindful awareness of thoughts, feelings and behaviours (Davis et al., 2015). In spite of this, SP/SR remains optional and the role of the therapist’s cognitions, emotions and behaviours in treatment, training or supervision has often been neglected in the extant CBT literature or training curriculum (Freeston et al., 2019; Leahy, 2008; Roscoe. 2021a; Wilcockson, 2020). For example, in the UK, the Roth and Pilling competencies framework which informs CBT training curriculum, fails to explicitly refer to this in either the generic, basic, specific, problem specific or meta-competencies sections (Roth & Pilling, 2007). In addition, their supervisor competences do not describe a need for supervisors to help supervisees with role transition during training or post-qualification or to make sense of their personal reactions to clients (e.g. counter-transference issues; Roth & Pilling, 2008). Furthermore, the Cognitive Therapy Scale-Revised (CTS-R), a widely used competence measure also fails to exclusively measure therapist awareness of their own therapy-interfering beliefs or behaviours across the twelve criteria (Blackburn et al., 2001). Despite this, research by Roscoe (2021a) found that CBT trainees are

receptive to exploring interpersonal and intrapersonal processes in training and supervision if these topics are introduced to the curriculum.

A case for examining the real-world impact of maladaptive therapists' schemas in CBT practice, training and supervision

Given the potential consequences of failing to identify and manage the impact of this multitude of schemas in CBT practice, training, and supervision (e.g. demanding standards towards clients, therapist drift and therapist burnout), there is a strong case for synthesising research that has been carried out to date. Establishing how, where and when maladaptive schemas present will assist in helping trainers and supervisors to improve their ability to recognise, formulate and respond to these difficulties across therapists' careers. It may also be helpful to have an overview of the current tools in existence (e.g., psychometric measures of maladaptive cognitions) for trainers and supervisors to help therapists quickly identify their blind spots, fears and safety behaviours. To the authors knowledge there have been no reviews of the therapist schema literature in CBT practitioners published. Given the length of time that has passed since Leahy (2001) first proposed this concept, and with an unprecedented increase in the number of CBT practitioners recruited to work in the English Improving Access to Psychological Therapies (IAPT) programme (see Clark, 2011) and similar models of care having been developed in Sweden, Norway and Australia (Clark, 2013; Gratzer, 2020) such a review is timely.

Purpose of the review

The purpose of this review is trifold. Firstly, it aims to synthesise existing empirical knowledge by searching the literature for studies that have been completed since 2001. For the purpose of this review, the term 'maladaptive therapist schemas' will refer to any recurring and inflexible cognitions that lead to either emotional difficulties for the therapist (e.g. anxiety, fear, anger, or shame) or to behaving in ways with clients that risk ruptures, boundary violations, or therapy and supervision being delivered in a sub-optimal fashion (e.g. frequent ruptures, inappropriate self-disclosures or avoiding, delaying or being excessively cautious with certain interventions (Katzow & Safran, 2010; Milne, 2020; Pugh & Margetts,2020; Roscoe, 2021b; Waller, 2009). Secondly, the merits and limitations of the existing work will be summarised before gaps in the literature are highlighted. Finally, specific aspects of CBT practice, training and supervision where therapist schemas are underexplored and warrant further investigation will be identified.

Review structure

When choosing between a scoping or systematic literature review Munn et al., (2018) advise that the former may be more useful when there is not a single or precise question to be answered. In looking to understand the characteristics of a phenomenon such as maladaptive therapist schemas which may have multiple origins, a scoping review allows for the identification of broad concepts within existing studies. The following research questions informed the literature search, selection strategy and subsequent discussion.

1. What studies have been undertaken about CBT therapist schemas (also referred to interchangeably as beliefs or cognitions) within CBT since Leahy hypothesised their existence in 2001?

2. What is known empirically about how, where and when CBT therapist schemas present in therapy, training or supervision?

3. What relationship, if any, exists between maladaptive CBT therapist schemas and therapy interfering behaviours?

4. What practical resources are available for trainers and supervisors to aid CBT trainee or supervisee awareness?

Method

The approach for this scoping review is based on Arksey and O'Malley's (2005) five-stage framework which comprises (1) identifying the initial research questions (see above), (2) identifying relevant studies, (3) study selection (see Figure 2), (4) charting the data, (5) collating, summarising and reporting the results. Following this process allows the researcher to demonstrate rigor and transparency and also enables the replication of the search strategy thus improving reliability of the study findings.

Ethics

As this was a review article, no participants were recruited. Therefore, ethical permission was not sought.

Identifying relevant studies

For this review an iterative approach was taken towards the literature given that therapist schemas are such a heterogeneous topic. For example, an initial database search of the term ‘therapist schemas,’ ’cognitive behavioural therapy,’ ‘cognitive behavioral therapy’ AND ‘supervision’ and ‘training’ using the Boolean operators ‘AND’ ‘OR’ in May 2018 produced only five results. The inclusion criteria were expanded to include studies that referred to either therapist cognitions or beliefs in addition to schemas and rechecked in January 2022. The first author conducted an initial search of the electronic databases PsycARTICLES, Medline, CINAHL and Academic Search Complete and additional literature sources were identified through the use of snowballing (searching the reference lists of identified articles; Moule, 2018), the screening of the reference lists of the included articles as well as studies known to the lead researcher from previous literature engagement. Lastly, the Cognitive Behaviour Therapist journal was searched with the terms ‘therapist schemas’ ‘therapist cognitions’ and ‘therapist beliefs’. As the purpose of this review was to scope rather than systemically scour the entire literature, no further journals were searched.

Reducing the risk of bias

The first author, a CBT trainer, supervisor, and therapist conducted an initial search of the databases and hand searches. The second author, a psychologist and non-CBT practitioner, repeated the searches using the same search terms to minimize the risk of bias in study selection.

Study selection

Articles were included in the review if the following criteria were met: (1) the article title referred to or mentioned the words ‘therapist schemas’ ‘therapist beliefs’ or ‘therapist cognitions’ in relation to CBT practitioners or the abstract reported on the presence or effects of therapist schemas in CBT practice, training or supervision (e.g. modes, fears , avoidance, collusion, transference, counter transference); (2) the article was published in a peer reviewed journal; (3) the article was published after 2001 (when Leahy developed the term therapist schemas’ in relation to CBT. Whilst research prior to 2001 is likely to include discussion of therapist factors, they are unlikely to refer CBT therapist schemas and those that are based on Leahy’s 2001 definition and (4) the article was available in English..

Articles were excluded if the following criteria were met: (1) they were a duplicate; (2) the article title or abstract did not mention therapist schemas, cognitions or beliefs in relation to CBT practitioners; (3) it is a clinical guidance paper based on expert opinion rather than an empirical study; (4) the full text of the article was not available; and (5) it was written before 2001.

Results

A total of thirteen (N=13) studies met the criteria for inclusion comprising (N=2) qualitative and (N=11) quantitative methodologies. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews format was adopted to categorise the results and to improve methodological rigour (Pollock et al., 2020; Tricco et al., 2018; see Figure 2). As the intention of a scoping review is to

rapidly assess the content and breadth of the literature, a quality assessment of the studies was not undertaken (Arksey & O'Malley, 2005).

Study characteristics

Studies were published between 2006 and 2021 (a more detailed summary of the studies can be seen in Table 1) and were carried out in the United Kingdom (N=6), UK and USA (N=1), USA (N=2), New Zealand (N=2), Australia (N=1) and Europe (N=1). Sample sizes ranged from (N=1) up to (N=637).

Participants

The majority of participants practiced some level of CBT or identified this as their primary theoretical orientation. The contexts in which participants delivered CBT were as follows: Participants drawn from a range of contexts (private practice, hospital, outpatient) (4 studies), staff working in IAPT services (3 studies), eating disorders (1 study), one with CBT supervisors (1 study), one with CBT trainees (1 study), Specialist Anxiety Disorder Service (1 study) and unstated (2 studies).

Summary of key findings

Three overall themes were identified in the research, (a) prevalence of therapist schemas (b) specific therapist beliefs and (c) therapist characteristics associated with the delivery of sub-optimal CBT or supervision with several studies spanning more than one theme. A summary of the key findings in each study is discussed below.

(a) Prevalence of specific therapist schemas

Only four studies (Haarhoff, 2006; Phin, 2013; Martin & Khan, 2015; Rameswari et al., 2021) referred to therapist schemas as defined by Leahy (2001).

(1) Haarhoff (2006) administered the therapist schema questionnaire (TSQ) (Leahy, 2001) to four groups of CBT trainees in New Zealand (n=64). The three most common schemas irrespective of whether the trainees were near the beginning or end of their training were 'demanding standards' (e.g., 'I must cure all of my patients'), 'excessive self-sacrifice' (e.g., the patient's needs are more important than my own') and 'special superior person' (e.g., 'I am entitled to be successful'). Haarhoff suggested that the TSQ could be used "as a screening device, a mechanism to extract general themes which may be relevant to stage of training, as a way to orientate trainees to the existence and implications of some of their beliefs about patients and therapy, and most importantly, as interpersonal signals which can be fruitfully employed as an intervention." (p130).

(2) Phin (2013) is the only other study to date to investigate the TSQ, testing the factor structure with a sample of (n=269). The results found that only four of Leahy's original fifteen schemas existed as independent factors. Whilst the majority remain valid, they were subsumed within seven overall schemas.

(3) Martin & Khan (2015) used an N=1 case study to reflect on working with a client presenting with complex Post-traumatic stress disorder. The therapist identified her own demanding standards schema (Leahy, 2001) activated during treatment failure with a traumatised asylum seeker. This had led to intensified efforts to engage the client in therapy and worry about their skill as a therapist. It appears as if the

identification of this schema was through written self-reflection rather than the use of the TSQ.

(4) Rameswari et al., (2021) used focus groups to compile a list of common therapy interfering cognitions. The list used items from several existing scales including the TSQ. In their sample of (n=12) IAPT therapists, underlying beliefs or rules for living were not considered favourable targets to work with as negative automatic thoughts were deemed more accessible and acceptable to clinicians.

(b) Specific therapist beliefs

Negative beliefs about CBT interventions

Three studies focused on how specific therapist beliefs would affect the utilisation of behavioural techniques (e.g., exposure-based methods) such as imaginal exposure and in-vivo exposure (Deacon et al., 2013; Meyer et al.., 2014; Meyer et al., 2020). Fears about the ethics of exposure, being subject to litigation and of making the clients worse appeared to drive therapist avoidance.

(5) Deacon et al., (2013) describes three linked studies exploring the relationship between specific therapy interfering cognitions and hypothetical treatment decisions based on several vignettes that were presented. For example, study one tested the psychometric properties of the Therapist beliefs about exposure scale (TBES) which had been derived from a review of the literature. (N=637) participants completed the TBES which contains twenty-one items, using a zero (disagree strongly) to four (agree strongly) method of rating. Example items include '*Most clients have difficulty tolerating the distress exposure therapy evokes'* and

'Asking the client to discuss traumatic memories in exposure therapy may retraumatize the client'.

(6) Meyer et al., (2014) sought to understand the reasons why therapists might exclude certain clients from exposure-based interventions. The authors developed and tested the Broken Leg Exemption Scale consisting of twenty-five items. Examples include '*The client has a comorbid personality disorder' and 'The client is afraid of harming oneself and/or others'.* The client characteristics that were most likely to result in exclusion were comorbid psychosis, emotional fragility, and reluctance to participate in exposure. Therapists who scored higher in anxiety sensitivity, a tendency to fear one's own anxiety reactions, as measured by the Anxiety Sensitivity Index-3 scale (Taylor et al., 2007) and who endorsed more beliefs on the (TBES) (Deacon et al., 2003) were more likely to exclude clients.

(7) Meyer et al., (2020) developed the Exposure Implementation Beliefs Scale, a ten item scale to better understand the purpose of therapist safety behaviours. A five-point Likert-type scale was used with examples items such as ' *to prevent being sued by the client'*.

Therapist resistance

Two studies captured different forms of resistance from therapist towards using computerised CBT with clients and engaging in Self-Practice / Self-Reflection programmes.

(8) Meisel et al., (2018) conducted a survey to understand therapist attitudes towards computerised CBT. Overall, the participants (n=33) believed that it would be less effective than face to face interventions for a number of anxiety disorders. Whilst

participants were able to endorse some benefits of this method, there was evidence of therapist mind reading and jumping to conclusions about what clients would think and feel if offered what they called ‘e-CBT’.

(9) Haarhoff et al., (2015) looked to understand the reluctance of some therapists to engage in self-practice and self-reflection (SP/SR) as previous studies had identified aversive responses amongst some therapists (Bennett-Levy et al., 2003; Chaddock et al., 2014). The SP element requires therapists to use CBT methods on themselves to deepen their understanding of various techniques and the SR component often involves the use of a workbook and group discussion and reflection (Freeston et al., 2019). The findings revealed a range of beliefs including some therapists not seeing the value of SP/SR, a perceived lack of time to engage with the process, a fear of being judged for revealing personal material in a group or a fear of intensifying existing personal problems

(c) Therapist characteristics

A number of therapist characteristics such as anxiety sensitivity, intolerance of uncertainty, perfectionism and self-esteem were described in the literature (Deacon et al., 2013; D’Souza et al., 2019; Meyer et al., 2014; Parker & Waller, 2019; Presley et al., 2017; Simpson-Southward et al., 2018).

(10) Simpson-Southward et al., (2018) sought to understand the role that supervisors might play in therapist drift and the psychological traits that might predispose them to this. The study was two-fold. Firstly, using three vignettes of depressed clients (a straight forward, a diffuse and a complex case) they found that supervisors were less likely to encourage evidence-based practice with the diffuse

case. Secondly, the anxiousness and self-esteem of supervisors were also measured using the twelve-item version of the Intolerance of Uncertainty (IU) scale (Carleton et al., 2007) which assesses prospective and inhibitory anxiety and the Rosenberg self-esteem scale (Rosenberg, 1965). Three categories of supervisory style also emerged in this study, 'alliance and technique focused', 'case management' and 'unfocused'. The first group showed higher self-esteem scores and low ratings for IU. In comparison to the other two groups, the unfocused supervisors tended to be less experienced as therapists and supervisors and relatively high in IU. Interestingly, despite being qualified the longest on average, the case management group scored highest in IU prospective anxiety suggesting that this does not necessarily reduce with clinical experience.

(11) Parker & Waller (2019) also found that IU and self-esteem were related to therapist use of techniques in CBT. Of the professional groups surveyed, CBT Therapists were the least likely to use behavioural methods (e.g., imaginal or in vivo exposure) and the second most likely behind psychiatric nurses to use cognitive methods (e.g., monitoring and challenging thoughts). Higher self-esteem was also associated with a greater use of non-CBT methods which the authors hypothesise as being due to therapists having "greater self-belief and do not see as strong a need to focus on evidence-based approaches." (p9).

(12) D'Souza et al., (2019) conducted a survey with (n=98) clinicians working in eating disorders services to understand the degree to which they attributed change to the techniques used or the therapeutic alliance. The authors analysed response to the IU scale and found that clinicians who scored highly in inhibitory anxiety were more likely to attribute successful client outcomes to the therapeutic alliance rather than specific techniques. Clinicians who placed more emphasis on the

alliance are less likely to push for key behavioural interventions in treatment such as in-session weighing and weight restoration.

(13) Presley et al., (2017) looked to explore the relationship between therapist perfectionism (TP) and client outcomes. From their sample of (N=36) IAPT high intensity therapists it was found that TP was less common than previous literature had suggested. Although the authors cite Leahy (2001) as part of their rationale to investigate this topic, the Perfectionism Inventory (Hill et al., 2004) was the measure that was used rather than the TSQ. Whilst they report that high scores on the 'Striving for Excellence' and 'High standards for others' subscales are associated with poorer client Patient Health Questionnaire (PHQ-9; Spitzer et al., 1999) scores, the majority of therapist scored average or below average scores. However, 31% scored above average in the subscale 'Concern Over Mistakes'.

Discussion

This scoping review had four key aims. The primary aim was to synthesise the existing research on therapist schemas within CBT. To our knowledge, no reviews have been conducted to date on this topic, therefore the intention was to scope the existing literature to identify broad themes and opportunities for further research.

Limited studies were found when searching the term 'therapist schemas' and 'cognitive behavioural therapy' alone therefore the search criteria was expanded to look for research based on therapist cognitions or beliefs. The majority of studies were quantitative, with research largely capturing negative beliefs about behavioural methods, psychological characteristics associated with therapist drift or resistance to particular adaptions of traditional CBT (computerised CBT and SP/SR).

The second aim was to establish how, where and when therapist schemas present in therapy, training or supervision. Only two studies investigated maladaptive therapist schemas as defined by Leahy (2001). Although Haarhoff (2006) found that self-sacrifice, demanding standards and special superior person were the most commonly endorsed schemas, the sample size was relatively small and specific to one institution. There remains little empirical support for their presence with the exception of the Phin (2013) study. The findings of this review suggest that other therapist characteristics such as age, gender, profession and level of qualification are associated with certain maladaptive beliefs. For example, Deacon et al., (2013) found that therapists who were older or female reported more negative beliefs about exposure whereas Meyer et al., (2014) found that therapists who were clinical psychologists or had attained a PhD scored lower on the Broken Leg Exemption Scale.

The third aim was to understand the relationship between maladaptive therapist schemas or beliefs and therapy interfering behaviours. Most of the studies in this review sought to either determine or validate the utility and psychometric properties of various scales that captured a range of beliefs about conducting exposure-based interventions (e.g. Meyer et al., 2020). The findings of Deacon et al, (2022) indicate that specific beliefs about the dangers or unacceptability of exposure therapy are implicated in therapist intentions to drift from evidence-based practice. Other studies looked at therapist intolerance of uncertainty, anxiety sensitivity or low self-esteem, and their correlations with restricted use of specific therapy or supervision methods (D'Souza et al., 2019; Simpson-Southward et al., 2018). IU and LSE are arguably different to beliefs, more likely to be representative of dispositional

characteristics (Carleton, 2012) yet could also be modified through similar methods used in CBT treatment (e.g. behavioural experiments).

The final aim was to ascertain what practical resources (e.g. formulations, interventions), if any, are available for trainers and supervisors to aid qualified therapists, trainees or supervisee awareness of their maladaptive beliefs and their potential consequences. No specific formulation templates that explain the origins and maintaining factors of therapist schemas were included in the featured studies. Martin & Khan (2015) used an (N=1) case study to describe how an 'antecedent-belief-consequence' (ABC) chain can be used to help therapists reflect on the role of their own beliefs arising from interactions with clients. Highlighting the client's behaviour as the initial antecedent, a section of contrasting thoughts, feelings and behaviours are captured to illustrate how one reinforces the other. The lead author describes a consideration of the role of culture and the use of CBT methods on herself to developing alternative thoughts however there is no diagrammatic representation of this process within the paper.

The scales such as the Exposure Implementation Beliefs Scale (Meyer et al., 2020), Therapist beliefs about exposure scale (Deacon et al., 2013) and Therapist Schema Questionnaire (Leahy, 2001) could be useful to introduce early in CBT training courses to normalise common therapy interfering beliefs and therapist drift. Surprisingly, none of the studies suggested the use of SP/SR strategies (e.g. Bennett-Levy et al., 2001; 2003) that could be utilised to manage the impact of maladaptive therapist schemas. Haarhoff (2006) provides a table with examples of how the three most common schemas could present yet the process of how a supervision dyad would introduce and work through this is not detailed.

Implications for future research

Schemas, beliefs, cognitions or traits? – the need for consensus

Overall, the studies appear to support Beck's generic cognitive model in that therapist beliefs about a wide range of CBT tasks, influences their emotions about performing them and this leads to avoidance or the use of safety seeking behaviours (Meyer et al., 2020; Waller, 2009). However, there is currently no agreement on which level of cognition to focus on (e.g. schemas, negative automatic thoughts (NATS) or psychological traits such as IU or LSE). Three studies explored the role of IU and LSE yet it is unclear how to classify these pre-disposing factors. On face value they do not fit with typical description of personality traits (Fletcher & Delgadillo, 2021), nor core beliefs in the traditional sense. They also represent more than situation specific responses such as NATS. Future research might look to better define where IU and LSE sit within therapist schema structures.

In the Rameswari study, NATS were seen to be more accessible and more relevant to the focus of CBT, however, this study was conducted across a single site therefore the generalisability of these preferences to work at the lowest level of cognition are difficult to make. In schema therapy, Young et al., (2006) developed the concept of modes, to identify specific cognitive, emotional and behavioural states where one or more schemas are activated (e.g. compliant surrenderer). Leahy did not go as far as writing about therapist modes although it is plausible that clients or supervisors for example, may activate child-like or avoidant coping states in CBT therapists and supervisees (Farrell & Shaw, 2018). Future studies might explore the prevalence of modes amongst CBT practitioners, their receptiveness to exploring them in training and supervision or the ways they might interfere with role transition,

supervision delivery or receipt, or refusal to deliver aspects of CBT formulation or interventions (Pugh, 2019).

Contextual schemas

Whilst individual vulnerability factors were highlighted, the role of contextual factors in the creation and maintenance of maladaptive schemas, beliefs or cognitions is underexplored (e.g. Parker & Waller, 2019; Presley, et al., 2017). Rameswari et al., (2021) point out that these therapist cognitions do not arise solely from 'intrapsychic processes' (p10) but through an interaction between the organisation in which one is employed, training experience and the idiosyncrasies of clients If we think more broadly about schemas as being 'organized elements of past reactions and experience that form a relatively cohesive and persistent body of knowledge capable of guiding subsequent perception and appraisals (Segal, 1988, p.147) then we can hypothesize the existence of contextual schemas. Examples might include within specific workplaces– e.g. 'we don't do those type of interventions here' / 'we don't do that in supervision', training schemas specific to institutions where therapists receive their training– e.g. 'this is how CBT is done' 'it's habituation or the highway!', and supervisor / supervisee schemas – e.g. 'supervision is exposing' 'supervision only covers Y' and Previous Professional role related schemas that interfere with role transition– e.g. 'this is how I assess patients, 'mental illness is caused by X' (Roscoe, 2022).

Utilising other methodologies

This review identified several gaps in the literature, including the methodologies that have been used to understand this topic. For example, most studies were quantitative which facilitate access to a large amount of data but allows less scope for understanding the reasons for specific beliefs or behaviours. Future studies might look to understand the lived experience of therapists and supervisors (e.g., Roscoe et al., 2022b) to assist with this. Autoethnography is also underrepresented in the CBT literature (see Chigwedere, 2018 for a rare example) and might also offer a unique and valuable contribution to our understanding of therapist schemas.

Practice implications

The studies in this review showed that negative beliefs about exposure, therapist intolerance of uncertainty and self-esteem are important processes to target in CBT training and supervision however, no guidance was provided on how to work with therapists and supervisors to manage their NATS, IU or self-esteem. The Declarative-Procedural-Reflective model of therapist skill development (Bennett-Levy, 2006) is a useful framework to help trainees understand the roles that their personal and therapist 'selves' play in their training. In contrast to personality traits which are often present from early childhood and viewed as fixed (see Fletcher & Delgadillo, 2021), therapist beliefs can arise at any stage in one's career and could therefore, potentially be amended and updated (Deacon et al., 2013).

Didactic teaching, self-practice of CBT methods and self-reflection on individual roadblocks to learning CBT offer a number of potential routes to modify therapist beliefs. Wilcockson (2020) has highlighted the need for CBT trainers to

consider the significance of role transition for different mental health professionals therefore helping trainees to consider the residual influence of their previous professional identity could highlight attitudes towards certain aspects of CBT (Roscoe et al., 2022a). The status quo points to the value of SP/SR being formally integrated within CBT training curriculums given that voluntary uptake is often low (e.g. Haarhoff et al., 2015). Consistent engagement in SP/SR from the start of training, continuing in supervision once qualified may help to foster a deeper and more consistent level of self-awareness amongst CBT practitioners (Freeston et al., 2019). Finally, organisational barriers such as how much therapist wellbeing is prioritised in different services is another factor to consider as one participant in the Haarhoff et al (2015) study stated "The system mitigates against self-reflection and analysis on the part of therapists" (p325).

Limitations

There are several limitations to consider from this review. Firstly, scoping reviews are intended to briefly map the literature, and as a result of the chosen methodology, quality assessments were not carried out on the studies included. Secondly, the relatively small number of studies included, yielded more results about specific cognitions rather than therapist schemas as defined by Leahy (2001) therefore an inconsistent definition remains. Only papers published in the English language were included and if more databases had been selected or if more reference lists or journals had been searched then more studies may have been identified. Thirdly, there are many types of therapist beliefs that were not captured within the findings. Consensus is required between accrediting bodies and training institutions around

which beliefs are most important to address in training and supervision. Fourthly, over half of the studies failed to disclose the ethnicity of participants and for those that did, the majority of participants were Caucasian. Whilst this is potentially representative of the current demographic of CBT practitioners, the cultural beliefs of therapists as well as experiences of racism are likely to have an impact on schema content and were not considered in the studies available (Beck, 2016; Naz et al., 2019).

Conclusion

This review highlights the need for further research on the origins, prevalence, identification, formulation and management of therapist schemas in CBT. Numerous psychometric scales have been developed as a response to concerns about therapist drift in routine clinical practice. Each measures specific types of therapy interfering beliefs, mainly related to the application of exposure-based methods. Several questions remain unanswered in relation to the contexts in which these beliefs arise or are maintained. Inhibitory anxiety related to intolerance of uncertainty was consistently found in the studies included within this review. CBT trainers and supervisors need to be aware of these concepts and have the skill to assist therapists to identify and reflect on how they impact their clinical practice (Bennett-Levy, 2019). We also know little about trainee, therapist, supervisor or supervisee receptiveness to working on their schemas during training and supervision. Whilst the work of Rameswari and colleagues (2021) is promising, lack of agreement on how best to frame therapist beliefs (e.g., as schemas, traits or as transient negative automatic thoughts) makes it difficult for researchers, trainers and supervisors to

know where to focus their efforts. No mechanisms exist at present to assist in the formulation or management of these psychological characteristics.

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Figure 1: The overlapping definitions of 'schemas'

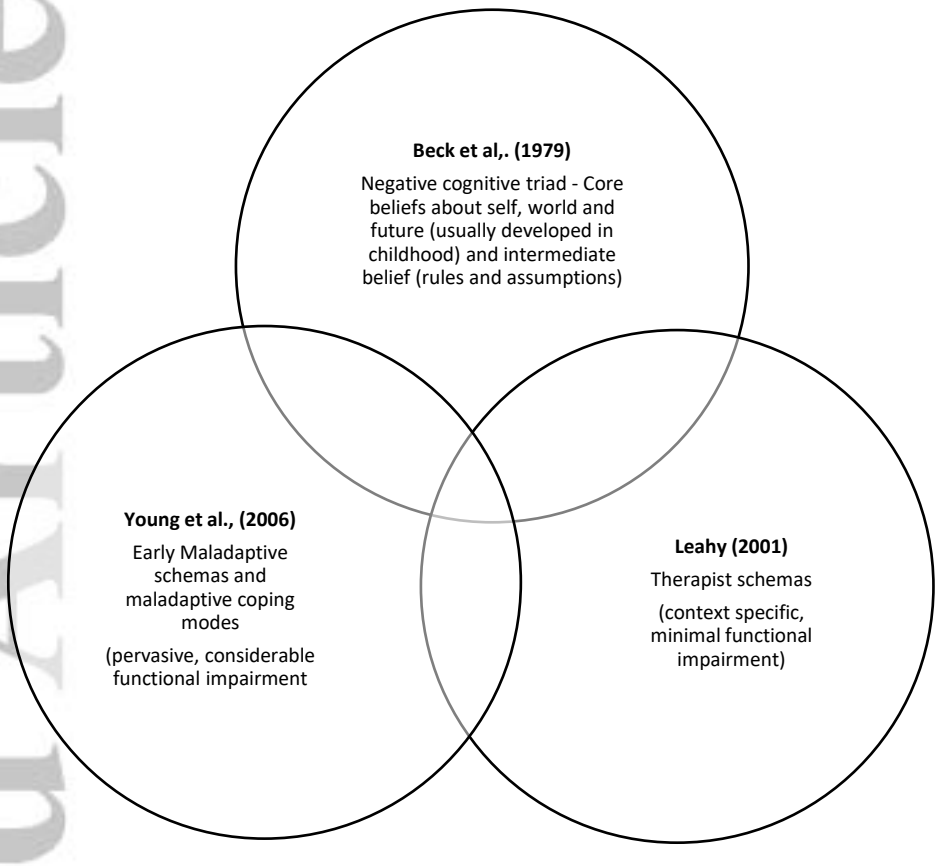

Figure 2: PRISMA Diagram

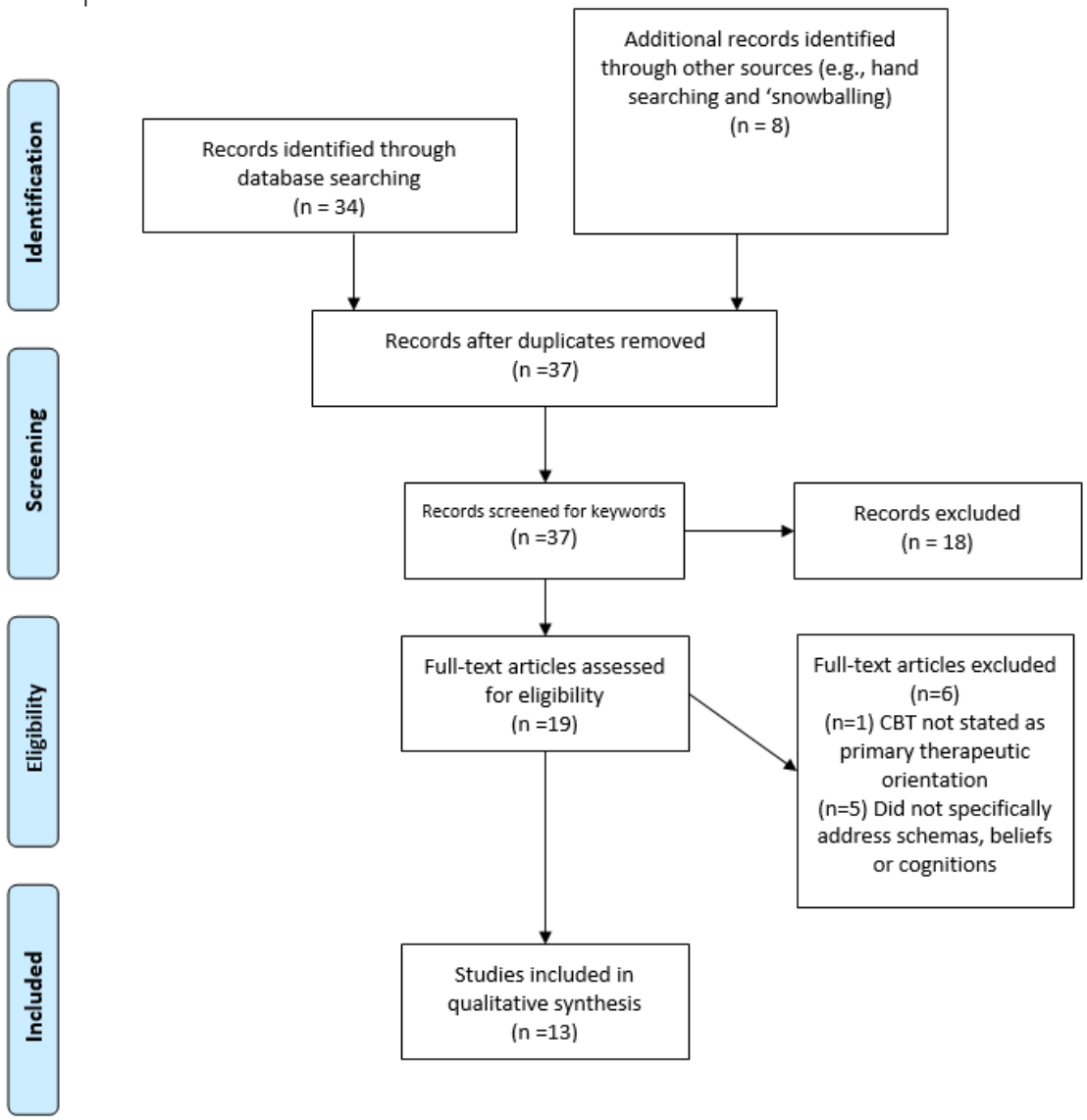

Table 1: Overview of included papers

Author(s)	Country	Context	Participants / Demographics	Method	Aims	Summary of Outcome(s)
Rameswari et al., (2021)	United Kingdom	Specialist anxiety disorder service	(N=12) CBT Therapists (8 Female; 4 male) Mean age 34 (SD=4.33) Ethnicity: White British (9), White and Asian (1), Black British (1), Greek-Cypriot (1)	Focus groups / Thematic analysis	To understand how best to conceptualise a scale for measuring therapist cognitions related to drift	Participants expressed preference to work at NAT level rather than rules/assumptions or underlying beliefs
Meyer et al., (2020)	Australia	Unstated	(N=98) Psychologists (79 Female; 19 male) Mean age 36.8 years (SD = 11.1) Ethnicity: Not stated	Online survey / Exposure Implementation beliefs scale; Exposure Therapy Delivery scale; the Broken Leg Exception Scale; therapist beliefs about exposure scale;	To identify beliefs that therapists have about exposure and the need to use safety behaviours by piloting the Exposure Implementation beliefs scale	Erroneous therapist beliefs (that they are protecting the client by avoiding exposure) were strongly linked to safety behaviour use
D'Souza et al., (2019	United Kingdom / USA	Eating Disorders	(N=98) Psychologists, CBT Therapists, Nurses, Social Workers, Dieticians, Occupational Therapists (91 Female; 7 males) Mean age 41.2 (SD=10.8) Ethnicity: Not stated	Online survey / Intolerance of uncertainty scale- short form	To understand factors associated with clinician non adherence to evidence-based treatments for eating disorders	Higher levels of clinician anxiety were associated with more belief in the effects of the therapeutic alliance and less belief in CBT techniques.
Parker & Waller, (2019)	United Kingdom	Various - unstated	(N=173) Clinical Psychologists, Counselling Psychologists, CBT Therapists, Nurses, Counsellors, Psychiatrists, Social Workers, Other	Online survey / Therapy Methods questionnaire; Intolerance of uncertainty scale- short form; Rosenberg Self-Esteem	To assess therapist routine treatment methods when working with anxiety disorders	Behavioural techniques were found to be the least utilised methods overall

			(118 female; 55 male) Mean age 45.4 years (SD = 11.15) Ethnicity: Not stated	scale; Negative Attitudes towards CBT Scale		
Simpson-Southward et al., (2018)	Europe	Supervisors	(N=42) Clinical Psychologists, Counselling Psychologists, Health Clinical Psychologist, CBT Therapists, Nurses, Counsellors, Occupational Therapists, Social Workers, Psychotherapists, Psychiatrists,Medical Doctor, Mental Health Practitioner, Unstated (26 Female; 16 male) Mean age 50.2 (SD=10.6)	Online survey / Intolerance of uncertainty scale- short form; Rosenberg Self-Esteem scale;vignettes	To better understand the characteristics of supervisors who may engage in drift when working with different depressive presentations	Three supervision styles identified with supervisors tending to recommend non-evidence based approaches to supervisees when cases are diffuse
Meisel et al., (2018)	United Kingdom	Improving Access To Psychological Therapies (IAPT) Service	(N=33) Clinical Psychologists, Trainee Clinical Psychologists, Counselling Psychologists, Psychological Wellbeing Practitioners, CBT Therapists, Counsellors, Assistant Psychologists Gender not stated Mean age not stated Ethnicity not stated	Survey	To understand barriers to therapists recommending computerised CBT to clients	Therapists on the whole believed e-CBT to be less effective and less well received by clients despite the evidence base suggesting different findings
Presley et al., 2017	United Kingdom	IAPT Service	(N=36) CBT Therapists (25 Female; 11 male) Mean age 39.6 years (SD not stated)	Perfectionism Inventory	To explore the relationship between therapist perfectionism and client outcomes in treatment	Perfectionism less prevalent amongst participants than previous literature had suggested

			Ethnicity: Not stated			
Martin & Khan, (2015)	United Kingdom	Not stated	(N=1), Female Age and Ethnicity not stated Trainee Clinical Psychologist	Case study	To show how a series of ABC formulations can be used to self-reflect on the therapist role in treatment failures	Demanding standards for self was identified amongst the chain of ABC's.
Haarhoff et al., 2015	United Kingdom	IAPT Service	(N=44) CBT Therapists, Psychological Wellbeing Practitioners Gender not stated Mean age 43 (SD=10) Ethnicity not stated	Therapist beliefs about SP/SR; Online survey	To explore therapist beliefs associated with refusal or disengagement with SP/SR programmes	Lack of time was found to be a major barrier to SP/SR engagement
Meyer et al., (2014)	USA	Private Practice, Hospital settings, outpatient clinics	(N=182) clinical psychologists, counsellors, psychologists, social workers, counsellors, marriage and family therapists, and pastoral counsellors (105 Female: 77 male) Mean age 47.1 years (SD =13.3) Ethnicity: (176 Caucasian)	Development and testing of the Broken Leg Exception Scale; therapist beliefs about exposure scale; Anxiety sensitivity index;	To assess the likelihood of therapists excluding clients from exposure treatment based on a number of scenarios	Higher therapist anxiety sensitivity together with negative beliefs about exposure were associated with excluding clients from exposure.
Deacon et al., (2013)	USA	Private Practice, Hospital settings As above	**Study 1** (N=637) (433 Female; 204 male) Mean age 35.3 years (SD = 12.2) Ethnicty: (603 Caucasian) **Study 2** (N=113) (74 Female; 39 male) Mean age 34.1 years (SD = 12.5)	Development and testing of the therapist beliefs about exposure scale; Anxiety sensitivity index; Four case vignettes (OCD, Social phobia, PTSD, panic disorder) Six month follow up to test the	To construct and pilot the Therapist beliefs about exposure scale (TBES)	TBES higher in females and older therapists and lower amongst clinical psychologists

		Workshop on delivering exposure therapy	Ethnicty: (110 Caucasian) **Study 3** (N=162) (123 Female; 40 male) Mean age 51.2 years (SD = 13.0) Ethnicity: Not stated	stability of therapist responses; exposure therapy vignette (OCD treatment) Pariticipants attended workshop on exposure treatment for anxiety disorders completing TBES pre and post attendance		
Phin (2013)	New Zealand	CBT Therapists in training, Public and Private sector Therapists	(N=269) Psychologists, Psychotherapists, Social Workers, Psychiatrists, Counsellors, Nurses, Occupational Therapists, Community Mental Health Workers, Trainee CBT Therapists (124 Female; 48 male) Mean age 44.5 years Demographics only collected for 64% of sample Ethinicity: New Zealand (92), European (38), Other (18), Asian (15), Pacific Islander (4), Pakeha + Maori (4), Maori (1)	Factor analysis of Therapist schema questionnaire (TSQ)	To investigate the psychometric properties of Leahy's TSQ	Only four of Leahy's fifteen schemas supported as independent factors
Haarhoff (2006)	New Zealand	CBT Training	N=64) Trainee CBT Therapists Gender not stated Mean age not stated	Trainee CBT Therapists completed TSQ (Leahy, 2001)	To identify the most common forms of therapist schemas amongst	Three most common therapist schemas were identified, and examples were given of when they might be activated in

			Ethnicity not stated		trainee CBT practitioners	therapy, training or supervision