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And Finally . . .

COGNITIVE THERAPY TRAINING STRESS DISORDER: A COGNITIVE PERSPECTIVE

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Abstract. A cognitive perspective of cognitive therapy training stress disorder (CTTSD) is presented. The authors present a cognitive model of CTTSD, preliminary data from randomized treatment trials, and discuss implications for effective treatment of CTTSD trainees.

Keywords: Cognitive therapy training stress disorder (CTTSD), losing face, letting yourself down, loser, found out eventually, unremitting shame and embarrassment, treatment failure.

Introduction

Cognitive therapy training stress disorder (CTTSD) is a common problem. Prevalence data by Lucky and Guess (1994) suggests rates as high as 100% on a bad day. Stress amongst therapy trainees has been reasonably well documented in a range of psychotherapeutic training contexts for many years, including psychodynamic (Franz-Terrence, 1924, *cf. Psychoanalytical Spoonerisms: An* ***id****iot's guide*), behavioural (Ratts & Pigeons, 1972), person-centred (Rodgers, 1980), and eclectic (Giveitago & See, 1984). It is only in recent years that attention has turned to the predictive variables associated with CTTSD (Russell-Grant, 1993).

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Most recent studies on stress associated with training as a cognitive therapist tend to focus primarily on the ''stress-diaembarrassment model'' (Clever, Bleeders, & Cockey, 1997), which hypothesizes that cognitive therapy trainees are characterized by a desire for competence fuelled by a pervasive fear of peer and supervisor disapproval resulting in, when competence is not perceived as being achieved, catastrophic predictions about professional and personal self-worth and consequent low mood (Sofar, Sogood, & Plausible, 1998). However, some researchers (Oyeah, Proveit, & Soon, 1997) have been instrumental in questioning a stress-diaembarrassment model, and it has been suggested that a number of mediating variables must be considered in terms of understanding vulnerability to CTTSD (Weir, Cleverer, Thanu, & Knowitt, 1998).

CTTSD is defined in DSM VI (ABE, 2000) as:

1. Recurrent and persistent thoughts, impulses, or images of failure as a cognitive therapist, leading to marked anxiety and increased rates of non-goal orientated behaviour (e.g. cupboard tidying, substance misuse (primarily chocolate), writing spoof articles, studious reading of peripheral texts, watching daytime television etc).
2. Exposure to the perceived competent cognitive therapist almost invariably provokes anxiety, awe, jealousy, or an intrusive interest in non-cognitive therapies.
3. The person vacillates between a recognition that the fear is excessive, dysfunctional, and unreasonable, and rumination that it might in fact all be horribly true.
4. The feared consequences have been present for at least one term's duration, causing significant disruption to sleep, leisure activities, restfulness, and how likely one is to come across as ''interesting'' at random social gatherings (excluding Fishmongers Fancy Dress Balls, and ''Elvis for Beatification'' Conventions: See DSM VI 328.0903, Avoiding Personality Disorders: A Few Handy Tips).

Although a number of models for various aspects of CTTSD have been developed (cf. Footlights, 1998, for a review), there has not until now been a comprehensive model of CTTSD based on empirical evidence and clinical experience, resulting in treatment protocols.

It is generally agreed by researchers in the field (Homeless, Cold, & Hungry, 1999), that the following factors are common to all current models: increased self-focused attention; processing of self as a therapist object; mildly negative therapy tape excerpts are interpreted in a catastrophic fashion; systematic underestimation of own abilities and overestimation about the performance of others; and selective focus on information that could indicate negative evaluation as a cognitive therapist. Early attempts to conceptualize CTTSD focused on a ''therapy paradox formulation'' (Little, Knowing, & Vague, 1993), whereby it was hypothesized that individuals most likely to undertake cognitive therapy training were, paradoxically, individuals most likely in need of cognitive therapy, thus predisposing such individuals to CTTSD through an ''it all comes out in the wash'' mechanism. This model has subsequently been found to have little empirical support (Sheer, Bunkum, & Ball-Lox, 1994; Ball-Lox & Drivell, 1995).

Seminal research by Staines, More-Staines and Fetish (1995) led to the ''personality node mindfulness-absence schematic-trait hypothesis'', whereby CTTSD could be understood in a pretty complicated way, but was subsequently discredited by Pernickety and Pedantik (1997) who produced empirical data indicating that Staines et al. (op. cit) had one of their arrows pointing in the wrong direction in their diagrammatic representation of CTTSD.

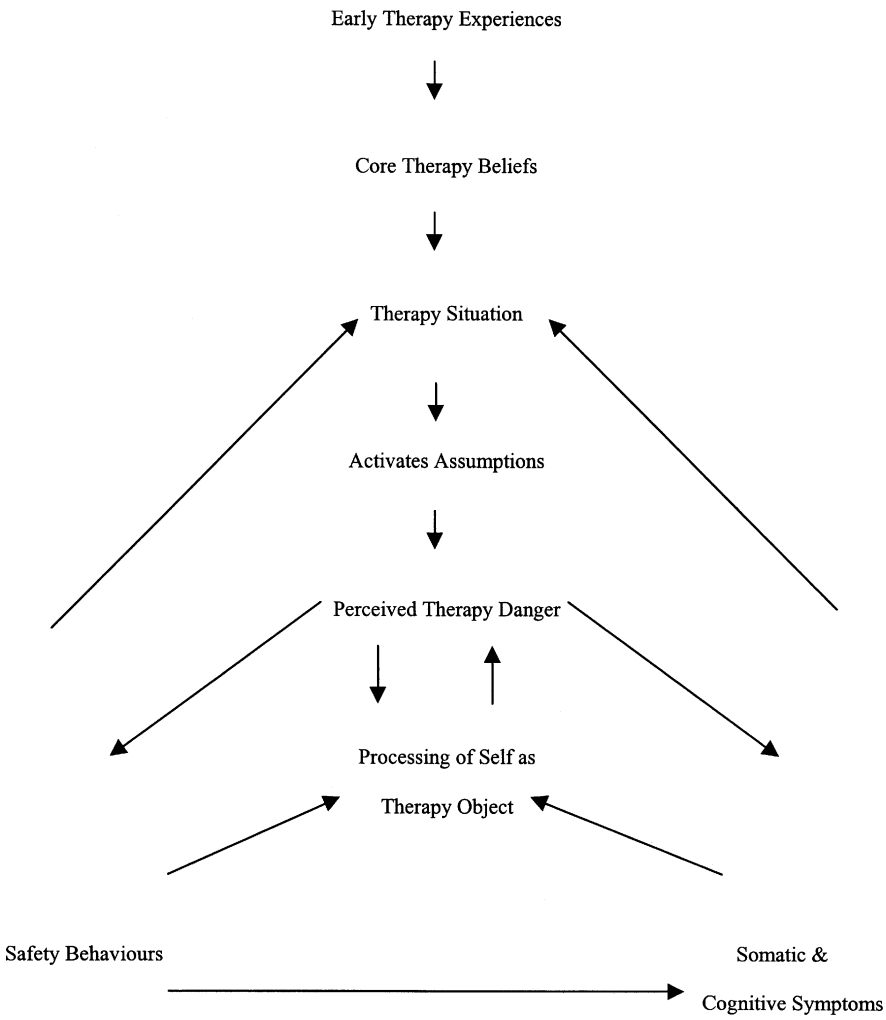

Figure 1. A model of CTTSD

The authors of this report suggest a cognitive conceptualization of CTTSD that has empirical support and allows the development of treatment protocols. In this model, it is hypothesized that one's early life experiences as a therapist lead to the establishment and subsequent maintenance of core therapy beliefs about the self as a therapist, others as therapists, and the world of therapy, and the development of general rules and assumptions to ensure sleepless nights. As a consequence, in specific situations where one's therapy competencies are, or are perceived as, being evaluated, some pretty spooky things happen. Underlying this is the propensity to process all incoming information in a therapist-referrent mode, which is distorted by a number of information-processing biases including dichotomous thinking, arbitrary inference, emotional reasoning, and generally scaring the shit out of oneself. A number of safety behaviours characterize CTTSD (outlined later) which operate to reduce adverse affect but fail to provide evidence of ''okayness'' as a cognitive therapist

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(Mentor, personal communication). These act to strengthen activated dysfunctional schema, resulting in not being the best dinner party guest in the world. The proposed model, with its multiple and cleverly placed arrows, suggests that this is something to ponder over for a whole heap of time.

Empirical data to support the hypothesized model

The authors have completed a number of research trials that provide compelling evidence to maintain their research grants. The model was tested by comparing the therapy beliefs of trainee cognitive therapists and a randomized control sample of non-therapists. The experimental sample was identified by contact with recognized cognitive therapy training institutes, and the control group by going through the telephone directory most Tuesday and Thursday evenings. Groups were matched in terms of age, gender, education, socio-economic status and the ability to draw a giraffe freehand. Subjects were rated in terms of: desire to be a cognitive therapist; previous professional training/exposure to cognitive therapy; therapy beliefs; and prior giraffonal contact. Two-way analysis of factor-loaded (Nil-Positive Inversion) variables (controlling for inter-medial discrete effects on an a priori assumption) provided a humdinger of a result ($\eth = 0.74$) in support of the model. (For fuller details of this method of statistical analysis cf. *Statistical methods for the sleepless and socially inadequate*, Bore, 1973). There is thus compelling empirical support for the proposed model.

Model implications

There are a number of core beliefs, assumptions, and safety behaviours that can be identified with, and predisposing, to CTTSD. This provides further support for the content-specificity model of emotional disorders. Table 1 summarizes the main findings.

Treatment implications

The treatment protocols developed on the basis of this model of CTTSD are broadly similar to other emotional disorders, in that they involve breaking the maintenance cycles, and then working on vulnerability factors. Indicators from the treatment trials suggest a mean treatment duration of 52 minutes and 27 seconds, as long as the therapist can talk pretty fast and dispenses with collaboration. Initial outcomes suggest that treatment failures at this stage have probably been misdiagnosed as having CTTSD, and will probably meet the diagnostic criteria for Therapist Inadequacy Personality Disorder, for which there are no current treatment protocols, but significant employment opportunities at a variety of fast food outlets.

We have found in our treatment trials that the use of imagery can have significant value and benefit within therapy. The following transcript from a therapy session by one of the authors (Competent) with a cognitive therapy trainee exemplifies this point.

T: You've told me how difficult things are for you at present, with all the pressure of assignment deadlines and your constant concerns about your inadequacy as a cognitive therapist. Do you have an image that goes along with that?

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Table 1. CTTSD characteristic variables

Common Self-Referent Therapy Beliefs
I am a crap cognitive therapist
I am innately flawed as a therapist and as a person
A giraffe would be a better cognitive therapist than me
I'm stupid and unintelligent
I don't know what's schemata with me
Common Other-Referent Therapy Beliefs
Everyone is a more competent cognitive therapist than me
Others are innately more skilled than me
They're good therapists because they're good people
Common Therapy-World Beliefs
The therapy world is dangerous and complex
The therapy world is full of highly skilled people
The therapy world is made up of psychologically intact people
Common Assumptions
Unless I appear intelligent and competent I will be kicked off the course
Unless I have others around me who make me feel intelligent and competent
I can never be a ''real'' cognitive therapist
I must be a competent cognitive therapist in every respect at all times
I have to get cognitive therapy right in order to be acceptable
I must be knowledgeable and skilled or people will laugh at me behind my back
Common Safety Behaviours
Try not to attract attention
Rehearse a question, to check that it is an intelligent one
Record Bing Crosby for your grandmother over therapy tape
Say nothing challenging or controversial
Take copious notes of every word said during workshops
Control mind, saying ''don't be pathetic'' ''pull yourself together''
Spend time in library looking at book titles
Enhanced use of assertive self-depreciation
Read up on a subject prior to the workshop
Verbal reattribution strategies e.g. Saying ''I'm stuck with this patient''
rather than ''I'm crap as a cognitive therapist''
Avoidance of assignments/procrastination

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P: Yes, it's like I'm all at sea, drifting around aimlessly, in constant danger of sinking and drowning. I'm kept afloat only by some driftwood. I'm imagining that I'm drifting towards Shit Creek.
T: And what feeling goes along with that image?
P: I'm absolutely terrified!!
T: Can you rate that between 0 and 100?
P: It's at least 100!
T: OK, I want you to stick with that image. But I want you to notice in your mind's eye a small sailing vessel on the horizon, that's heading towards you. As it gets closer, you notice that this vessel has all the other course participants aboard, and as it draws alongside you, they all reach over and pull you on board. What is the feeling that goes along with this image?
P: I feel rescued. And safe.
T: Can you rate that feeling?
P: I guess it feels like 90.
T: And what has happened to that feeling of terror?
P: It's gone down. It's only about 5 or 10.
T: Good. Now what do you think could be the take home message in a bottle from this?
P: I guess it's that we're all in the same boat.

Conclusion

A cognitive model of CTTSD has been presented along with empirical data supporting the model. Treatment implications have been outlined. There are a number of ways that further applications of the model might qualify for extended research grants, and it would seem highly likely that at least one of the authors will be a professor by this time next year, you mark our words.

Acknowledgements

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Note from the Editor

This article proved very controversial with the reviewers. Given the importance of the topic and the interest generated. I felt it would be most helpful to publish the reviews along with the article itself. The original authors were very keen indeed to have the last word, so the two reviewers' comments are then followed by a response from the original authors.

NB: It is normal practice for reviewers to remain anonymous. Therefore, would readers please note that Imaprof is not necessarily connected in any way with Mark Freeston, nor is Sue Denham necessarily connected with Carole Sherwood . . . but they might be.

Reviewer 'A' comments

The authors are to be congratulated on a brave but ultimately foolhardy attempt at addressing a still rare clinical condition. This manuscript presents an attempt at a cognitive formulation of CTTSD, a condition previously seen in only a few isolated locations such as Newcastle and Oxford, but more latterly has been springing up throughout the country. What this formulation fails to describe and account for is the time course of the disorder. What is remarkable about the disorder is the biphasic onset

where a short period of euphoric enthusiasm and optimism turns into severe lack of confidence, deskilling and feelings of total confusion. The next phase is well described by the authors, but they fail to mention the surprisingly high rate of spontaneous remission that occurs approximately 10 months after onset. It should be noted that the British variant has a shorter time course than in Europe. There are some isolated but increasing cases reported in continental Europe where there is a longer but less intense form that seems to run over 3 years (Outrain, Longha, van Udoo, 2000).

The authors may want (if they know what is good for them) to refer to a brilliant analysis of a totally *unrelated* problem. Eclectic Confusion Disorder (Imaprof & Fullovit, 1997). ECD occurs through exposure to too many workshops while avoiding routine clinical work and the obligation to work from multiple theoretical perspectives on the rare occasions the therapist actually sees a patient (Imaprof & Urnot, 1998a, 1998b, 1998c; Imaprof & Uwannabe, 1999). Integrating the incisive theoretical advances proposed by this brilliant mind into this somewhat lacklustre manuscript would undoubtedly increase its theoretical importance (and the reviewer's citation ranking).

In fact, the present manuscript would indeed be improved by redefining CTTSD as a minor and insignificant sub-type of ECD and completely forgetting Figures 1 and 2. It would then be necessary to point out the equally brilliant therapeutic approach developed by Imaprof and Profit (2000), (see attached brochure with workshop dates) called OTRT (Outmoded Technique Rediscovery Therapy). OTRT brilliantly combines a range of techniques popular in the 1960s and early 70s for treating a range of nasty habits. The approach had fallen out of favour following an early meta-analysis that mistakenly concluded that it was ineffective (Watsan, Effeksize, & Hookares, 1978). Imaprof has brilliantly pointed out that a key component of the therapy was missing (see Imaprof & Royalties, 2001, to see which component was missing). Thus with such minor modifications this manuscript would represent a significant contribution to the literature (and my fame and fortune). In its present form it may well describe the clinical features of CTTSD in a modest way but does nothing for my professional standing and retirement fund. Finally, the authors would learn a great deal if they assisted an OTRT training program instead of wasting their time with CT training.

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Comment to Editor

With some minor reworking, as suggested above, the paper would represent a significant contribution to the literature. However, in its present form has absolutely no merit. *P.S.* The normal arrangement stands for % of take on my next workshop tour.

Reviewer ''B'' comments (Sue Denham, CTTSDs Anonymous)

This is a timely piece of research into CTTSD. As the authors rightly point out, this disorder is both prevalent and disabling, affecting a large number of therapy trainees, reducing their ability to function effectively and in some cases, rendering them completely inept in their chosen profession. However, I am surprised that in the literature review, no mention is made of recent studies conducted by the National Association of Therapies' Scientific Research Unit, Sheffield (N.A.T.S. R. U.S.). In particular, the work of Watts, O., Badd, A., Bout, H.A.T. *et al*. provides a comprehensive cognitive account of the core beliefs and dysfunctional assumptions underlying CTTSD and offers a very convincing evidence-based, empirically supported, scientifically sound (but often impenetrable) treatment protocol for even the most intransigent non-responders (''The Worst Thing Happened – How Failing Can be Fun'', Watts, O., Badd, A., Bour, H. A. T. *et al*., 2001 – arrow quotient: 24). They have also published a very useful book on the interpretation of cognitive models entitled *Which way is up: A guide to arrows and their meaning* (2000) Target Publications, Hastings.

In terms of design, I find it surprising that the authors used the telephone directory from which to select their control group. In my view, they would have been better advised to use more modern methods. Did they not, for example, consider recruiting the control group via internet chat rooms or the very good chain of Irish bars, e.g. O'Neills, in which all manner of human life can be found on a Friday night? I would also question the decision to employ freehand giraffonal image creation. There is now a very sophisticated software package, widely used in the social sciences, for producing computer generated giraffe imagery. However, the methodology is basically sound and the author's statistical analyses appropriate, although it might have been worth investigating the effects of reversing the polarity in line with Kirk, J.'s (e.g. 1970) ''final front ear'' approach. This has been shown to improve the consumption of porridge and engine performance over time.

Overall, though, an importance piece of work, which is likely to be of great interest (and therapeutic benefit) to the journal's readership.

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Watts, O., Badd, A., Bout, H. A. T. & Soe, O. N. (2000). *Which way is up? – A guide to arrows and their meaning*. Hastings: Target Publications.

Worthless' last words

We find the comments on the above paper ''interesting'' (*cf* Sneer & Yonn, 1998). The prime reason for not citing the N.A.T.S. R. U.S. research was one of expediency, just as it was expedient for them to head-hunt and subsequently employ our two best postgraduate researchers.

Although we did indeed consider a research design that elicited the control group from public hostelries, in the end we elected for the telephone directory in light of the unfortunate understanding in *The Pig and Suspender Belt* last April between Dr Competent and East Workstead Rugby Club Second XI. We do not believe the methodological integrity of our research was compromised in so doing, and Dr Competent realizes that in retrospect he was in error attempting to merge our shared research on CTTSD with his own individual research on ''Social Sequelae of Tourette's Syndrome''.

We reject the comments of Imaprof on methodological, theoretical and moral grounds. Methodologically, we are concerned that the development of the central tenets of Eclectic Confusion Disorder are based on an introspective single case study, rather than a more rigorous scientific approach. The theoretical underpinnings of OTRT, based on early work in the 60s and 70s in the animal laboratories, have not, we feel, been fully empirically validated with human subjects. In particular, we are greatly troubled by the notion of introducing bird seed in the context of psychological therapy. Morally, we have some concerns about Imaprof's practices, particularly since he attempted to entice the then girlfriend of Dr Lemonde-Terrible to travel with him on his Canadian Workshop Tour in 1998, as his ''personal fitness trainer''.

We have subsequently heard on the conference grapevine that Imaprof is suffering from ''False Mammary Syndrome'', characterized by wanting to make oneself appear bigger than is actually the case. Whilst we fully support keeping abreast of developments, we are aware of the fine line between this and making a t*t of oneself.

I. M. Worthless, U. R. Competent & O. Lemonde-Terrible

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Editor's Note

This discussion is now closed.