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How to Train Experienced Therapists in a New Method: A Qualitative Study into Therapists' Views

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Background: Implementation of new effective treatments involves training, supervision and quality control of therapists, who are used to utilize other methods. Not much is known about therapists' views on how new psychotherapy methods should be taught.
Objective: The purpose of this study is to get insight in how experienced therapists experience the training in a new method so that training methods for experienced therapists can be improved.
Method: Qualitative research using focus groups. For an RCT on the effectiveness of schema therapy (ST) for six personality disorders more than 80 therapists were trained in ST. They applied the ST-protocol after 4-day training, with peer supervision and limited expert supervision. Sixteen of these trained ST therapists from seven health institutions participated in the focus groups. The transcripts and records of the focus groups were analyzed on repeating themes and subthemes and in terms of higher order categories.
Results: Therapists appreciated didactical learning methods but particularly valued experiential learning. Especially, novice ST therapists missed role plays, feedback to learn required skills and attitudes, and attention to their resistance to new techniques (e.g., empathic confrontation and imagery). Peer supervision gave emotional recognition, but therapists lacked regular advice from an ST-expert.
Conclusions: In teaching a new therapeutic method didactic teaching is necessary, but experiential learning is decisive. Experiential learning includes practicing the new therapy and reflecting on one's experiences, including resistance against new methods. Emphatic confrontation, case conceptualization, role play, peer supervision and opportunities to ask an expert supervisor during peer supervision are found to be helpful. Copyright © 2016 John Wiley & Sons, Ltd.

Key Practitioner Message:
- Especially by Eperiential learning besides didactic learning.
- By practicing with many role plays including feedback.
- By reflecting on one's experiences including resistance against ingredients of the new method.
- By peer supervision with opportunities to ask an expert supervisor.

Keywords: training of practitioners, supervision, implementation, qualitative research, focus groups, schema therapy

INTRODUCTION

The implementation of new treatments in clinical practice is a challenging but important undertaking (Shafran *et al.*, 2009). One of the issues is how to train therapists in a new method, and to setup a system so that the newly trained method is delivered as intended, and the quality of delivery is maintained at high enough levels. Barber, Sharpless, Klostermann and McCarthy (2007) described the kind of therapists' knowledge and skills that has to be trained as '*limited-domain intervention competence*'. This relates to the therapist's skills to apply a specific technique or form of treatment. How to train therapists in this kind of competence, and how to evaluate this kind of competence, is important for successful dissemination and implementation of new treatments. Surprisingly, little research is carried

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out in this field. Usually, it is recommended to use a two-step approach to teach a method to a therapist. In the first step, didactic learning is used to transfer the background and knowledge about the method. In the second step, supervision is offered where the therapist discusses the client with a supervisor (Beidas & Kendall, 2010; Sholomskas *et al*., 2005; Weissman *et al*., 2006). Fairburn and Cooper (2011) discuss some fundamental shortcomings of this training format. In particular, the fact that therapists have only limited ability to see how the therapy is carried out is a problem. Another problem is that this form of training is not suitable for large groups of therapist because of the costs and practical difficulties. There is also little known about what effective training and supervision methods are, while it is generally acknowledged that training and supervision are important (Prasko, Vyskocilova, Slepecky, & Novotny, 2012). We have little systematic knowledge about the educational needs and perspectives of the therapists that are supposed to implement the new treatment in practice. Insight into the perspectives of those that need to be trained might help us to improve training and other implementation issues.

When therapists, experienced in other methods, are trained in and have to practice a new treatment, specific issues emerge. For instance, therapists have to learn to not use techniques they might apply automatically, and the new treatment might raise questions and resistance because it involves methods and techniques that are antithetical to those that they are used to apply. As implementation should not wait until new generations are trained, it is pivotal for successful implementation that we improve our understanding how *experienced therapists* should be trained in new methods and how they should be guided when they start to apply the new treatment in practice.

Despite a limited body of evidence for the empirical benefits of supervision and training (e.g. Ellis & Landany, 1996; Milne & James, 2000), good quality randomized trials of psychological therapy ensure that therapists not only adhere to treatment protocols but also deliver the therapy in a competent manner. Without this, internal validity can be compromised, limiting clinicians and researchers to attribute any differences in patient outcomes to the treatment they received. It is therefore important to report the training of the therapists in clinical trials (Roth, Pilling, & Turner, 2010).

As suggested by Roth and Fonagy (2005), our study into the perspectives of therapists on training a new method recruited experienced therapists, ensured that training was offered before the study started, offered ongoing supervision and monitored the delivery of interventions. As to supervision, it is widely accepted that supervision of psychotherapists, especially in the early years of practice, is important for professional development and to ensure optimal patient outcomes (Bambling, King, Raue, Schweitzer, & Lambert, 2006). But as O'Donovan and Dyck (2001) concluded 'we don't know nearly enough about what contributes to effective training to be dogmatic about what training needs to comprise.'

The purpose of this qualitative research is to offer insight in the views and experiences of experienced therapists about a training practice, supervision and peer supervision in a new treatment. We take the case of schema therapy (ST) as an example because we had an excellent opportunity to gather meanings and experiences of experienced therapists who had to be trained in a new method, after which they were required to deliver the treatment to patients. Besides this opportunity, ST is an integrative therapy that requires various qualities of therapists, making training and supervision of additional interest. The results of this study may help to improve future training, supervision, peer supervision, dissemination and implementation.

METHOD

Design and Theory

In the context of a large scale multicenter randomized controlled trial (RCT) on the treatment of personality disorders (PDs), executed in regular mental health institutes, we studied the views of therapists trained in a new method, ST, on training, protocol, and (peer) supervision (Bamelis, Evers, & Arntz, 2012; Bamelis, Evers, Spinhoven, & Arntz, 2014). The RCT provided an excellent opportunity to gain an understanding of the experiences with becoming a therapists in a new method, as a large number of experienced therapists had to be trained in the new method, after which they were required to deliver the treatment to patients allocated to them on the basis of randomization. The necessity to deliver the treatment to patients for which it was developed and the broad implementation of the new method offered us the chance to make an in-depth study of the experiences of newly trained therapists.

We chose for a qualitative study, because we were interested in the insiders' perspective of therapists, and not much is known about the training of therapists in a new method. Qualitative methods are appropriate for the exploration of a topic (versus hypothesis testing). Qualitative research is open to unexpected findings without *a priori* restriction of what could be found. More specifically, we chose for a focus group study. Focus group interviewing is a research technique that collects data through group interaction on a topic determined by the researcher (Morgan, 1996). The focus group stimulates deliberation and interaction among participants, which results in a diversity of perspectives and deepening of various arguments on the discussed topic. Moreover, it is a relatively cheap, easy and flexible way to invite participants to share their experiences and opinions on a certain topic.

Focus group techniques are used in the various disciplines, including family therapy, psychotherapy and other fields of health research (Madriz, 2000; Capuzzi & Gross, 2005; Sprenkle & Piercy, 2005; Kamberelis & Dimitriadis, 2011).

The New Therapy

Schema therapy is an innovative, integrative therapy. The therapy was developed by Jeffrey Young and colleagues (Young, 1990, 1999). ST is developed for patients with chronic characterological problems, e.g. those that don't profit enough from traditional cognitive behaviour therapy. The therapy focuses on schema modes, which describe the various states of (dys)functional emotional, cognitive and behavioural patterns that begin early in development and repeat throughout life. ST builds on traditional cognitive behaviour therapy but uses insights about other forms of therapy and schools with relatively more emphasis on exploring the origins of psychological problems in childhood and adolescence, on emotive techniques, on the patient–therapist relationship, and on maladaptive coping styles (Young, Klosko, & Weishaar, 2003).

Schema therapy was evaluated for the treatment of borderline personality disorder (BPD) and appeared to be an (cost)effective approach (Giesen-Bloo *et al*., 2006). From 2006 to 2011, the (cost) effectiveness of ST for six other PDs was studied in a RCT performed in collaboration with 12 mental health institutions in the Netherlands. The investigated form of ST was a 50 session treatment designed for cluster C, histrionic, narcissistic and paranoid PDs. Based on an earlier study, the treatment seemed to be an (cost) effective approach (Weertman & Arntz, 2007).

Schema therapy is an integrative therapy that requires different qualities of therapists. At the start of the study, the first wave of therapists who were selected by the participating centres to deliver ST were trained in 4 days by a non-Dutch expert. The choice for a 4-day training of a large group of therapists by an expert was motivated by the wish to interest, recruit and train a large number of therapists at once. Financial restrictions prohibited training of smaller groups. At the time, in the Netherlands, ST was still new and there were no renowned Dutch experts.

The training programme existed of a presentation in which the basic theory of ST, outcome of research, the schema modes, the early maladaptive schemas, ST with PDs, with an emphasis on BPD and narcissistic PD, were educated. In addition, two imagery group exercises were carried out, a video was shown with a part of a therapy session and two role plays were conducted: one with pairs of participants and a role play by the trainer himself in front of 80 participants. The participating therapists received a syllabus with the presentation and background information with questionnaires and texts on specific techniques used in ST. Because of unexpected attrition of sites and therapists, a second cohort of 20 therapists was trained later by another trainer. Like the first cohort, the second cohort received presentations, explanations and (video or life) examples. Different from the first cohort, the second cohort practiced all the techniques in pairs, while the trainer corrected and supported them and the examples focused more on applications with the pertinent PDs.

After training, therapists started to work with the ST protocol within the RCT. They followed a weekly peer supervision group with colleagues. The peer supervision groups had the possibility to call the supervisor when they had difficulties. Besides this, there were annual national supervision days organized with the Dutch supervisor (the fourth author). During these days, there was the possibility to ask questions, to practice difficult situations in role plays and to share with other therapist outside the peer supervision groups.

Participants

Two focus groups were held of each eight therapists, after almost a year of the beginning of the RCT. The sample of 16 trained ST therapists was heterogeneous in terms of age, gender, work site and therapeutic background. One therapist was trained elsewhere; the others were all from the first training cohort. Four of the 16 participants from the focus group were advanced ST. This is roughly equivalent to the approximately 24% advanced schema therapist in the total group of therapists. Participants were affiliated with 7 of the 12 health institutions in the Netherlands that were study sites. Because two of the final 12 sites were added later to compensate for sites that withdrew, they are not represented in the present study (their therapists were trained later in the 2nd cohort). No volunteers were available from another three sites. Table 1 provides an overview of the background of the participants. The ST therapists were invited by email to participate in the focus groups, and the coordinators of each health institute were asked to send two ST therapists to participate. The focus groups were planned on national supervision days of the RCT, so that the therapists did not have to travel extra for this study.

Protocol

To prepare the group meetings, important subjects were listed and checked in an exploratory interview with a ST-therapist. There were three main topics: (1) the treatment protocol and the expectations therapists had about

Table 1. Background characteristics of focus group participants

Gender and age	Schema therapy experience	Years of experience	Training	Therapy school	Therapy school references
Focus group 1					
1. Female	Advanced	7	University Psychology Psychotherapist	Group Therapist (NVGP)	CBT, Group Therapist
2. Female	Advanced	30	University Psychology Clinical psychologist	Group Therapist (NVGP)	CBT
3. Male	None, just practical experience	8	University Psychology Clinical Psychologist	Family Therapist (NVRG), Sexology	System therapy
4. Female	None	9	University Psychology Health psychologist	Family Therapist (NVRG)	CBT
5. Male	None	6	University Psychology Health psychologist, Education to Clinical Psychologist	Family Therapist (NVRG), Client Centered (VCGP)	Eclectic/ integrative
6. Female	None, just practical experience	26	University Psychology Health psychologist, Psychotherapist	Family Therapist (NVRG), Group Therapist (NVGP)	CBT
7. Female	None, just practical experience	15	University Medicine Psychiatrist	Pesso Therapy	Family Therapist
8. Male	Advanced	25	University Anthropology Psychotherapist	Group Therapist (NVGP)	CBT
Focus group 2					
1. Female	Starter, one course and practical experience	20	University orthopaedics Clinical Psychologist	Group Therapist(NVGP), Family Therapist (NVRG), Sexology	CBT, Family Therapist
2. Male	None	10	University Psychology Clinical Psychologist	Family Therapist (NVRG), Group Therapist (NVGP), Sexology	Client centered
3. Male	Advanced	32	University Psychology Clinical Psychologist	Group Therapist (NVGP), Sexology	CBT
4. Female	None	9	University Psychology Health Psychologist	Family Therapist (NVRG)	CBT, Client Centered, Psychoanalytic, Eclectic/ integrative
5. Male	None	30	University Psychology Clinical Psychologist	Group Therapist (NVGP), Sexology, Family Therapist (NVRG)	Client centered, Psychoanalytic
6. Female	None	14	University Psychology Clinical Psychologist	Group Therapist (NVGP), Family Therapist (NVRG), Sexology	Client centered, CBT
7. Male	None	35	University Psychology Clinical Psychologist	Family Therapist (NVRG), Group Therapist (NVGP), Sexology	Group Therapist, Psychoanalytic
8. Female	Starter, followed one course	18	University Psychology Health psychologist, Psychotherapist	Family Therapist (NVRG), Group Therapist (NVGP)	Client centered, Family Therapist

Note. The three levels of professional training of psychologists in the Netherlands are (from low to high) as follows: Health Psychologist, Psychotherapist and Clinical Psychologist. NVGP is a Dutch association for group psychotherapy. NVRG is a Dutch association for relation and family therapy. CBT is cognitive behavioural therapy.

it; (2) the qualities of a ST-therapist; and (3) suggestions from the participants to improve the training and supervision and the protocol based on their experiences with the application of ST. At the start of the meeting, a short explanation of the focus group method was provided, which included explanations of anonymity, and the way of working and analyzing. Approval was asked to audiotape the conversations. Hereafter, the participating therapists introduced themselves.

Data Collection

The duration of focus groups is normally between 2 and 3 h (Abma & Broerse, 2007). In this research, they lasted only 1.5 h because of time limitations (therapists also had to participate in the supervision). Focus groups make use of a moderator. The role of the moderator is to keep the discussion focused on a topic while encouraging the group to interact freely (Morgan, 2001), and to maximize the interaction between participants. Control is shared with participants (Madriz, 2000; Kamberelis & Dimitriadis, 2011). The moderator of the first group was the third author (TA) the first author (MtN) observed the process and made notes. The second focus group was led by the first author (MtN) and was observed by the third author (LB). The two focus groups were audio-recorded with an mp3 media player after consent.

Both focus groups followed the same protocol to be able to compare data (Tables 2a and 2b). The protocol described the topics, timing, instructions and working methods. For the first instruction, keywords were written on large papers.

Table 2a. Script focus group experience experts schema focused therapy (SFT)

Purpose:
• To exchange experiences and opinions of therapists who work according to schema focused therapy (SFT).
• On the basis of some keywords (SCID, additional, tape recording, session reports, peer supervision, conditions) and smileys;
1. How did the implementation of the research go?
2. Which aspects of the study are difficult?
• On the basis of 'the ideal therapist';
1. What are the characteristics of the ideal SFT therapist?
2. What is the difference between yourself and the ideal SFT therapist?
3. Which problems do you experience between the ideal and yourself?
• On the basis of 'an imagination of being Yeffrey Young'.
1. Imagine you're Yeffrey Young. What are the three aspects you would like to change in the protocol of SFT?
2. Why would you change that elements in the protocol and do you have suggestions on how to change this?

Participants were invited to place stickers with different emoticons onto the large papers with the keywords.  This exercise served as warming up, and the intention was to encourage interaction between research participants (Kitzinger, 2003). It also gave the opportunity to ventilate certain emotions. Together with the participants, it was decided that some topics would be analyzed more in detail and other subjects would be parked and passed on to the researchers. We parked the subjects that were part of the research design (SCID, tape recording, session reports). For this article, we focus on the views on and experiences with the training and the peer supervision (weekly sessions with three to eight schema therapists).

Hereafter, the protocol prescribed a projective technique: therapists draw 'the ideal Schema Therapist' for themselves. A projective technique was chosen to try to deepen and personalize the conversation. After a couple of minutes, the participants were asked to tell what 'the ideal Schema Therapist' looks like. All the characteristics and skills were written on a large paper on which a therapist was drawn. After this instruction, we asked the therapists to tell in which way they differed themselves from this ideal therapist. Hereafter, a question was asked about the expectations of the therapist about the application of ST in the study population. The focus group ended with a short imagery exercise by asking the participants 'imagine you are the developer of ST, what would you change in the protocol for the treatment of PDs'. The participants told successively about their ideas, and while they did this, they reacted to each other to deepen the reactions.

Data Analysis

When it comes to analyze different focus groups, it is extremely useful to have common external reference points such as provided by the use of large papers on which keywords were written (Kahn & Manderson, 1992). The recordings were typed out verbatim and outlined. The transcripts and records were analyzed on repeating themes and subthemes, in line with a content analysis (Lincoln & Guba, 1985). Content analysis combines specific, individual data into more general statements. Individual researchers read the transcripts. All emerging themes in the transcripts were marked, labelled and compared within the research team to increase reliability and to reach consensus on the discussed themes (Barbour, 2001; Mays, 2000). The themes of all transcripts were grouped together. This resulted in a list of recurring themes and subthemes. Hereafter, the first and second author analyzed the results in higher order categories. No use of computer software was made.

Table 2b. Time schedule

Time	Part	Content
11.00–11.30 AM	Preparation of the location	• Whiteboard or flipchart. • Ensure coffee/tea and a biscuit/cake • Ensure nameplates • Ensure words related research on flap over • Large paper with points to discuss later • Large paper for development points • Ensure stickers emoticons • Ensure pens • Ensure man drawing ideal therapist
11.30 AM	Start meeting and introduction	• Chairman welcomes everyone and explains about the research and the plans for the meeting: • Proposals for guidance and roles: X monitors the process and Y is moderator • Indicate that the conversation is being recorded to process the data and not lose any information. The information will be handled confidentially, and the recording will be erased after processing (X monitors the recording). • The objective of this focus group; In the study, you have to fill out several questionnaires. Today, we would like to hear from you, separately from the questionnaires, how it is to work as a SFT. We consider that it important that you are heard as experts working with SFT in the study. Your experience can then be included in the implementation of this method. The central question is as follows: what are your opinions about and experiences with SFT, and what does it mean for you to work with this form of therapy. This is not an intellectual debate on this form of therapy, but about your personal experiences. • Inform about the programme of this meeting. We have time until 13:00 PM. • Would you like to write your name on the nameplate in front of you?
11.40 AM	Introduction Round	• Ask participants if they want to briefly introduce themselves? •Which institution do you work? • What is your age? • Original therapeutic orientation? • Which personality disorder has your patient in this study? • How many sessions did you have with your patient in this treatment?
12.00 PM	Start parking flap	• This day is devoted to the large RCT study. Perhaps, there have been not enough room to address all and difficult topics in this research setting. Based on participant observation in a peer group and two exploratory interviews with SFT therapists, we have a number of words (below 1–6) written dealing with the investigation. These are on the large paper. The question is as follows: what feeling comes to you when reading the following words. Stick the sticker that describes this feeling. If a sticker is not enough, you are free to write related words. Markers are added.

(Continues)

Table 2b. (Continued)

Time	Part	Content
		1. Training. 2. SCID. 3. Recording calls. 4. Report calls. 5. Intervision. 6. Others. • Moderator makes an inventory: what stickers are where? • Moderator starts discussion to deepen: why does this word has those stickers on it? • Moderator turns to improvement paper: which topics of the study have to improve? • Moderator summarizes; • Moderator indicates that participants have parked these subjects and we will communicate these with the research group. The rest of the morning is devoted to SFT.
12.30 PM	The ideal therapist	• Moderator introduces: if you have to draw the perfect SFT therapist in a sketch together, what would he/she look like? • At flap drawing an man/woman • Checklist; 1. Attitude. 2. Personal variables 3. Background 4. Skills. 5. Human vision 6. Methods. 7 ..... • Moderator starts deliberation: now, we have collectively figured out what the specific aspect of the ideal SFT are, would you indicate in what way you differ from hem/her. And tell if you do meet problems because of this difference. • Moderator summarizes what has been said.
12:45 PM	Young	• Finally, the moderator asks participants to do a little imagination exercise. Relax by sitting down and close your eyes and breathe deeply. Imagine that you are Yeffrey Young and you are in charge. Think for yourself of three important things to change in this therapy. • Open your eyes. Write down the inventory of the top three changes on a yellow paper, and explain them to the other participants. • Moderator starts deliberation to deepen the top three changes • Checklist 1. Questionnaires schedules 2. Model modes 3. Case conceptualization 4. Imagination 5. Reparenting 6. Behavioural changes • Summarize
12:55 PM	End	• Moderator: We have come to the end of the focus group. Before we stop, are there any questions or comments? • To whom might I submit the final report as a content check? • Possibly a repetition of the focus group about 2 years. • Thank you for your cooperation!

Quality Measures

Table 3 gives an overview of the measures that were taken to enhance the quality of the study.

Procedures
Explanation and the reason for the research and the focus group is explained to the therapists in the beginning of the focus groups.

Member Checks
Outlines of the transcripts and (sub)themes were sent to the therapists for a 'member check': they were asked to check if the outline matched with what they had said and meant (Meadows & Morse, 2001).

Investigator Triangulation
The first and second author discussed the codes given to the raw data until consensus was reached, also known as investigator triangulation (Mays, 2000).

Saturation
We also discussed whether or not saturation was reached. Saturation occurs when there is a repetition of findings and no important other findings pop up. Saturation is a sign that it is unlikely that further data acquisition will yield new information.

Fairness
Focus groups require a moderator who is familiar with group dynamics to prevent dominance of individuals and group pressure. In the introduction and during the focus group, the moderator tried to create an empathic atmosphere in which the participants felt free to share their vulnerability and opinions. At each step of the process, the moderator also tried to give room to each participant to express his/her personal views. In the analyses of the transcripts, the equivalence of the contribution from the different participants was checked.

RESULTS

Quality Assessment

The member check learned that participants recognized the outlines, themes and subthemes, and no major corrections were made.

Higher Order Categories

In the results, two main categories of learning came to the front, which we labelled *didactic learning* and *experiential learning*. Didactic learning were forms of learning in which the trainer was the expert, explaining theory, methods and techniques. The persons who want to learn a new method are receptors of the teacher's experience and knowledge. Experiential learning referred to forms of learning through experience. Results are discussed according to these two main categories.

Findings within Higher Order Categories

DIDACTIC LEARNING

Comments by participants referring to didactic learning could be grouped into two subcategories: didactic learning during the training and didactic learning during peer supervision.

Didactic Learning during Training.

Generally the therapists said that they found the four-day training given by the expert interesting and inspiring.

> *I found the training interesting, inspiring were the days*

Table 3. Quality procedures

Procedures	Explanation and reason
Member check	To enhance credibility, all participants received an interpretation of their focus group with the question whether they recognised the analysis (Barbour, Mays)
Investigator triangulation	Different investigators were involved in the analysis process. The investigators arrived at the same conclusions, which heightened our confidence (Mays).
Saturation	This is the point in data collection when no new or relevant information emerges and data collection stops. In order to verify whether we reached the saturation point, we made analysis during the process of data collection. After two focus groups, no new codes emerged, and therefore, saturation was reached.
Fairness	In focus groups pressure to consent, group think and dominance of one or more participants should be prevented by an experienced moderator and protocol that includes all participants (Madriz; Kamberelis & Dimitriadis)

All participants found the four day training a bombardment of information. It was mentioned that practicing during these four days, in smaller groups would have been a solution.

The program was very full; it really filled your head
There was hardly room for your comments
I found the training a kind of overflow, there was so much to digest

One therapist said:

In fact it is a very technical thing that ST and I do not think you are done with it in a pressure cooker of 4 days. You will not manage when it is said go to do yourself. You have so much to experiment to get it right according to the protocol. The protocol is not fully defined.

The word 'protocol' means to several therapists that it is a well-defined, step by step, detailed roadmap, describing what to do each session. In contrast, the perception of the participants was that they had to figure out a lot on themselves. More practical handles how to do this would be appreciated. It was mentioned that after the training, watching DVD's is something you can fall back on because the specific techniques are shown on the DVD's.

In summary, the therapists found the training interesting and inspiring. Watching the DVD box was found helpful. To learn the therapy better and feel more comfortable, the participants suggested to provide training in small groups, with room for one's responses and resistance, and for discussion. The results also show that a distinction should be made between therapists who have some experience with the ST treatment and therapists without ST experience, in line with Bennett-Levy (2006). The more experienced ST therapists appreciated the way of knowledge transfer more. The less experienced therapists experienced more anxiety, which they attribute to the way of training. More specifically, the didactic training method evoked fear and uncertainty rather than confidence. Additionally, it was stated that the knowledge transfer mainly by lectures evoked resistance. The need of professionals to think for themselves was at stake.

Didactic Learning during Peer Supervision.

Several times the need for an expert during peer supervision came to the front.

The problem is that we are all beginners, I miss supervision. The danger is there that it takes a lot of time to solve problems, and that the professional development stagnates, if you do not really have a leader who has experience and who dares to drive.

The peer supervision groups were composed by the therapists from the institution where the ST therapists are working and consist of three to eight persons. Participants in a peer supervision group in this study are, for practical reasons, mostly colleagues of the same department. The focus groups showed that the therapist had the need or wish that an expert was participating in the peer supervision group. A therapist named that their peer supervision group used the possibility to email the national supervisor. They experienced that as very helpful. This suggestion was received very enthusiastic by the other participants from the focus group. Additionally, it was mentioned that it would be helpful if there was actually someone from the central organization who could once in a while participate in the peer supervision at various stages of treatment. Therapists identified the danger of stagnation in the therapy and stagnation of professional development if one wrestles too long with a situation without asking for suggestions by an expert.

EXPERIENTIAL LEARNING

Comments by participants referring to experiential learning could be grouped into subcategories: experiential learning during the training and experiential learning during peer supervision.

Experiential Learning during Training

Participants mentioned that they felt resistance against ST during this training.

I felt that I was handed a new religion, I was overwhelmed by the vision of the master, and I had to do it like him.
I felt forced into a straitjacket of so and so I have to do differently, and I do it wrong.

The therapists emphasized that it would have been nice if during training, there would have been more room for discussion of this resistance.

However, there was a difference in perception of the training between therapists who had worked previously with ST or had followed other ST-courses, and therapists who had first come into contact with this form of treatment. A therapist who had previously taken courses worded this as follows:

I'm excited about that every time, and I notice now again, new facets are presented, other options, and I appreciate that. You become more familiar with it bit by bit.

A therapist who was new with the method said the following:

it would have been better if I had practiced more. I started to get insecure because of the research design you have to do it really good
While practicing techniques you can experience success and trust more on the positive effects of the method.

The participants suggested that to learn the therapy, everyone has to treat one patient well-coached for 1 year, and that such 4-day training should be given two times.

An important therapeutic technique of ST is empathic confrontation. Therapists emphasized that this is difficult to learn. Some quotes to illustrate are the following:

How directive and how empathic do you have to be?
I can fall into directedness to avoid emotions.
I do miss some power.

By empathic confrontation, the therapist is trying to find the optimal balance between empathy and confrontation with reality, by which the patient is helped. When the therapist is able to find this balance, the patient feels really understood, maybe for the first time in his/her life. Because they feel understood, they will feel the need to change, and they have more appreciation of the healthy, alternative views that the therapist confronts the patient with. Subsequently, the patient experiences the therapist as their ally against the schema and does not experience the confrontation as a personal attack (Young, Klosko, Weishaar, 2005). The handbook describes that the risk exists that therapists do go too far to one of the sites. They might be too empathic by which they do not force the patient to see reality, or they are too confronting and the patient starts to defend herself/himself. In both cases, it is expected that the patient will not change.

Participants of the focus group suggested that it would be nice if they can practice more with this technique, in such a way that there is less fear to confront or to be empathic. They also said that it would be preferred that the protocol was more specific in the fact that this is a real pitfall.

An important technique of ST is Imagery. A problem that almost all therapists pointed out was the difficulty of imagery exercises during ST.

My patient is actually constant in the detached protector mode and it is very difficult to get beyond. They do not trust what they see, nor their own body signals, and avoid them all. So they are sticking to talking about the model, about the schemas, and that is counterproductive without experience, so just more of their defense.
Imagery is difficult for avoiders because they have no emotional experience.

The participants emphasized that this is very different from the treatment of people with BPD. With an imagery exercise with someone with BPD 'the modes fly across the room'. Many had not mastered to do imagery with patients with avoidant PD. The request was that the manual and the training must be clearer that this is a trap, that there must be more discussion about how to manage this and that the manual makes a difference between the approach of BPD and avoiding PD. 'We need more tools to get beyond the extreme avoidance'. A focus on this was missed in the training and the need to practice more in the training. Some quotes to illustrate are the following:

We need to practice more
I need several success experiences to keep trying with difficult patients

In summary, the therapists emphasized that they like more room for discussion of resistance. Novice participants expressed the need for successful experiences during the training, which may be reached by practicing during the training. Especially the novice participants felt that they were instructed to act in specific ways only because it must, without being given the opportunity to try the methods out, master the techniques and get convinced by experience. And finally, it was stated that the art of mastering the new treatment, including empathic confrontation and imagery work, lies to a large extent in much practice and experimentation.

Experiential Learning during Peer Supervision

Almost all therapists perceived the peer supervision as pleasant and useful

Nice to know all patients.
Nice one hour time.
Very helpful.
You can make mistakes, and dare to make mistakes, so that creativity can occur. Peer-supervision helped me to encourage me with this.
It is an excellent opportunity to be very creative.

But there is also some ambiguity in the perceptions. A therapist expressed this as follows:

Sometimes I think, during the peer-supervision, it will never work with me; and other times I think there's music, and not so much shame, and enthusiasm, which varies very much.

Useful Suggestions for Improving Experiential Learning through Peer Supervision

Most of us are sitting in the corner of avoiding, every time we start peer-supervision with other things, for example; about troubles in the organization, a lot of peer-supervision time is lost

To avoid the above and to use the peer supervision better, the participants gave a number of useful suggestions:

> *More active role-plays.*
> *Not just talk but do.*
> *I would also like to use the tapes to peer-supervision, we used the tape and we all have brainstormed about what a possible intervention would be. I found it very productive.*
> *Use more tapes, even if it is confrontational.*
> *Look DVD's.*

Personal Aspects Related to Experiential Learning during Peer Supervision

> *I get some involvement with patients who have a little child side so sometimes I find them quite difficult to let go. So I think that peer supervision is really a necessity to help me let such issues go*
> *Maybe you can say more generally that counter transference and analysis of it remains very essential in this model. In the peer-supervision, we have paid little attention to this. It would be foolish not to do this, now we're thinking about it.*

Schema therapy focuses, as mentioned above, on the maladaptive schemas of the patient. But, as stated in the handbook (Young *et al*., 2003), schemas of the therapist are important as well. Some participants used the word countertransference, in terms of ST, one can speak of schema or mode activations in the therapist. Schemas or modes of the patient may conflict with the schemas or modes of the therapist. By knowledge of their own schemas and coping styles, the therapist can avoid mistakes. In contrast to this, the perception of the participants was that in the training, in the therapy, in the handbook and in the peer supervision, too little attention is paid to schema or mode activations of the therapist.

In sum, the therapists mentioned that they find it pleasant to have peer supervision, but sometimes it could evoke other emotions. They indicate that they generally lack an experienced therapist in the composition of the peer supervision group and suggest closer contact with the research team. To better use the peer supervision, they suggest to do more active role-playing, to use treatment tapes from themselves and to watch DVDs with ST exercises from the training. Specifically, more attention should be paid to personal aspects.

DISCUSSION

Comments by participants could be labelled in two categories, didactic learning and experiential learning. Both categories emerged in comments related to training and comments related to peer supervision issues.

The main issues that emerged about *didactic learning during the training* were the following. First, therapists found the training interesting and inspiring. Second, the less experienced therapist experienced more anxiety, fear and uncertainty than the more experienced ST therapists. Third, it was stated that the knowledge transfer mainly by lectures evoked resistance. Fourth, the wish to receive the training in small groups was expressed. Fifth, watching the ST DVD box was found helpful.

The main issue that emerged about *didactic learning during peer supervision* was the need for a participating expert in the peer supervision group in order to avoid the risk of stagnation in the therapy if a group wrestles too long with a situation. The suggestion of emailing the expert was called, or once in a while participating by the expert in the peer supervision group at various stages of treatment.

The main issues that emerge about *experiential learning during the training* were the following. First, participants liked more room for discussion of resistance. Second, the novice therapists needed successful experiences during the training to get convinced about this method. This could be reached according to the participants by practicing more during the training, trying the methods out and master the techniques. And finally, it was stated that the art of mastering this method including empathic confrontation and imagery work lies to a large extent in much practice and experimentation.

The main issues that emerged about *experiential learning during peer supervision* were the following. First, participants stated that they find it pleasant to have peer supervision, but sometimes it could evoke other emotions. Second, participants generally missed an experienced therapist in the peer supervision group. Third, they suggested to do more active role-playing to use treatment tapes from themselves and to watch DVDs with ST exercises from the training. Fourth, more attention should be paid to personal aspects, notably the activation of participant's own schemas and modes during treatment.

Among the most important feedback from the participants about learning a new method is the need for practicing by role plays. Especially for novice therapists this seems pivotal. The need for a lot of role-playing, constructive direct supervision and training in small groups for less experienced therapist is also highlighted by Bennett-Levy (2006). Fairburn and Cooper (2011) indicate that it is important to assess the skills of the therapist or in other words, the outcome of the training. They suggest a method in which the therapist shows some scenarios in a role play with a simulated patient. So role plays seems essential in both learning and assessing skills. Although one can question whether role plays represent clinical reality sufficiently, the participants of this study indicated role play as a very helpful experience. The reason is probably that learning new therapeutic procedures is mainly based on the acquisition of procedural knowledge (Bennett-Levy, 2006), that is better acquired through practicing the

procedures than by trying to memorize the verbal explanations. The fact that the practicing situation is not a perfect representation of the clinical situation is probably of less importance than the use of the optimal learning procedure.

Besides this, it is important to create small training groups. In a training with many participants, therapists report they feel more fear and insecurity. Trainers should be aware of resistance from the therapists to a new treatment. Not adequately addressing resistance interferes with the learning process, and thus with the implementation of the new treatment. According to the therapists, resistance must be a subject in the training, the supervision and the peer supervision. Moreover, according to the therapists, training in small groups provides a better format to address resistance than training in large groups.

Peer supervision and supervision by an expert are in the experience of the therapists essential to work with a new protocol. This is to conform the literature in which it is widely accepted that supervision is important (Bambling *et al*., 2006; Mannix *et al*., 2006). The results of this study indicate that in peer supervision of novice therapists, an expert supervisor is needed. Therapists felt that it took them too much time to solve difficulties in the therapy, which might have negatively influenced the treatment of the patient. Case studies have examined how parallel processes influence patient outcome, and stagnation in peer supervision how to deal with issues in the case brought in might further contribute to stagnation in that treatment (Alpher, 1991; Doehrman, 1976a, 1976b; Friedlander, Siegel, & Brenock, 1989). The therapists again suggest to do more active role-playing, to use treatment tapes and to watch DVD's with ST exercises from the training and to have the opportunity to ask an expert supervisor.

Looking at specific difficulties in learning ST, therapists commented that the training should be adapted as much as possible to the population they are expected to apply the new treatment to, and that specific difficulties with applying the techniques with the pertinent disorders should be addressed. In the specific case studied, therapists reported that working with modes seemed easier with BPD, for which the mode model was originally designed, than with other PDs, such as avoidant PD. They suggested to pay more attention to the application of the mode model to other PDs in the handbook, the training and the expert and the peer supervision. Doing an imagery exercise with the avoidant PD was experienced as extremely difficult, and they missed practical training in how to do this. Experiences from patients (ten Napel-Schutz, Abma, Bamelis, & Arntz, 2011) and experiences from therapists assessed after the trial (de Klerk, Abma, Bamelis, & Arntz, 2013) also suggest that it might be very difficult to do an imagery exercise with patients with avoidant PD.

Finally, it is remarkable that many participants would have liked a more experiential training approach than they received, given the fact that ST is a therapy strongly relying on experiential approaches to change old patterns and install new ways of approaching challenges

Limitations of the Study

The protocol that was used for the focus groups was quite structured to be able to compare the two focus groups. A less structured approach may deepen the conversation even more and create more room for participants. For the composition of the groups, we asked the institutes to send two participants. This may have had an impact on the information given as some participants might have felt not free to say everything because they know their colleagues. For future research, we suggest to separate colleagues in different groups. The duration of the groups was 1.5 h due to time limitations, longer durations might lead to more findings. The advantage of the focus group is that one has the experiences and opinions of 16 therapists in a short time, and they can help each other with forming an opinion. However, a personal interview can focus more on the personal story. Also by doing two focus groups 1 year after the trial started, we got a snapshot of the moment. A longitudinal study on the developmental process of the therapists might be a good next step.

Validation of the Conclusions

The second cohort was trained in a very different manner, with three times as much attention to practicing specific techniques as the first cohort. The different training method was not based on the results from the focus groups (the training took place before the focus groups were held) but on the preferences of the trainer. The present results indicate that this training method better meets the needs of trainees, in particular when novice. Importantly, the effectiveness results indicate that training method had an influence on patient dropout and clinical outcome (Bamelis *et al*., 2014) underlining how important it is to listen to the needs of therapists when training them in a new treatment.

Impact of the Focus Groups

Because of the reactions of the therapists in the focus groups, the research staff added two extra supervision days during the trial, which was welcomed by the therapists. The therapist perspectives yielded hypotheses about why the implementation of a new treatment can be more or less effective. Besides this, the focus groups are a learning platform and a voice for the therapists. The suggestions of the therapist will hopefully be

included in manuals, training, supervision and other aspects of the implementation process of new treatments.

Recommendations

A number of key recommendations are made to improve training, supervision and peer supervision in order to improve implementation of new treatments.

- Differentiate in training experienced and less experienced therapists, and in those that already have some experience in the new method and those that do not.
- The trainer's attitude during didactic learning and experiential learning must give space to the therapists to think for themselves.
- Explicitly address resistance to and questions about the new treatment. Small groups are better suited for this than large groups.
- Use a lot of role-plays and practice in the training, with immediate assistance and feedback from the trainer(s).
- More attention should be paid in manual, training, supervision and peer supervision to working with the specific patients and the pitfalls related to them.
- Peer supervision groups are essential.
- Create the possibility for a peer supervision to communicate with an expert (e.g., if regular expert supervision is too costly, arrange ad-hoc supervision on request).
- After a training, at least some follow-up supervision is highly recommended.
- Use focus groups in your implementation process to listen to the experiences of the users; this may bring unexpected aspects to the front.

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