The Schema Therapy model

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Schema Modes

• Moment to moment emotional states that reflect the current clusters of cognitions, emotions and behaviour

• State-like results from interaction between underlying Schema and resulting coping style

• Categories of modes: child, coping, parent, & adult
MODE MODEL ACCOUNT FOR SYMPTOMS OF BPD

Vulnerable child

Angry Child

Impulsive Child

Punitive or demanding parent

Detached Protector
<table>
<thead>
<tr>
<th>Individual Modes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>vulnerable child</td>
<td></td>
</tr>
<tr>
<td>angry child</td>
<td>intense anger, poor control</td>
</tr>
<tr>
<td>impulsive child</td>
<td>impulsive behaviour</td>
</tr>
<tr>
<td>punitive or demanding parent</td>
<td></td>
</tr>
<tr>
<td>detached protector</td>
<td>emptiness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All modes</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Self injury behaviour, suicidal ideation</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Mode flipping</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Emotional reactivity and stable sense of self and stable relationships, Dissociation and reality disconnection</td>
</tr>
</tbody>
</table>
Vulnerable child mode

LOOK & FEEL:
Unable to get own needs met feels helpless & overwhelmed

SYMPTOMS:
Depressed, hopeless, needy, frightened, victimized, worthless, unloved, lost, frantic efforts to avoid abandonment, idealized view of nurturers
Angry & impulsive child mode

LOOK & FEEL:
Acts impulsively to get needs met and vents angry feelings usually in inappropriate ways

SYMPTOMS:
Angry, impulsive, demanding, devaluing, controlling, abusive, suicidal or therapy quitting threats
Punitive parent Mode

LOOK & FEEL:
Punishes the person for expressing needs and feelings, or for making mistakes

SYMPTOMS:
Self-hatred, self-criticism, self-denial, self-mutilation, anger at self for neediness
Detached/Angry Protector

LOOK & FEEL:
Cuts off needs and feelings; detaches from people, doesn’t want to feel or think

SYMPTOMS:
Doesn’t want to talk in therapy or doesn’t come to therapy, surly, wont do imagery, depersonalization, emptiness, boredom, substance abuse, binging, self-mutilation, dissociation, psychosomatic complaints
Treating BPD common modes

- Strengthen the healthy adult mode which tends to be underdeveloped.
- 'Limited reparenting' with healthy adult, punitive parent, 'protector' & child modes.
- Confront and banish the punitive parent mode which typically is not helpful.

Healthy adult

Detached (or angry) protector

reduce the need for the 'protector' mode which switches off from inner pain via emotional, physical or chemical withdrawal.

healing the pain and despair of the bullied, abandoned, abused child. Confront and set limits on impulsive child.

Punitive parent

Angry/impulsive child mode

Vulnerable child
Dealing with vulnerable child mode

• Limited reparenting: provide basic needs - safety, protection, nurturance, connection, autonomy, acceptance, freedom, spontaneity and play
• In SFT therapist not neutral, provide extra care, extra sessions, phone accessibility, give compliments
• Tools
  – Imagery rescripting, two-chair technique, role play
Combating the Punitive Parent

• Educate about universal needs and feelings
• Reattribute childhood rejection to others’ issues
• Reattribute adult failings to schemas, not self
• Highlight successes and positive qualities
• Fight the Punitive Parent through imagery or two-or-more-chair technique
Unique and common processes in schema therapy

• Nothing new, just an evolution of CBT wrapped up in mode terminology

• An eclectic therapy
  – Similar to PDT, more on childhood, more on therapy relationship, more on defences
  – Similar to CBT, education focus, therapist is active

• Need for empirical test
Design

• Therapists members of professional associations (CBT, PDT, SF)
• Australia and overseas
• 20 from each orientation
• Measure *Psychotherapy Process Q-Set*
CBT most characteristic items

- Patient's treatment goals are discussed
- Therapist works collaboratively with the patient (e.g., seeks feedback, checks how the patient is responding in session)
- Therapist asks for more information or elaboration
- There is discussion of specific tasks or activities for patients to attempt outside of session
- Therapist communicates with Patient in a clear, coherent style
- Therapist communicates the change process to the patient in terms that they can understand
- Therapist is sensitive to Patient's feelings, attuned to Patient, empathic
- Therapist encourages Patient to try new ways of behaving with others
Other highly discriminative CBT

<table>
<thead>
<tr>
<th>Item</th>
<th>F Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist actively exerts control over the interaction (e.g. Structuring, and/or introducing new topics)</td>
<td>68.83</td>
</tr>
<tr>
<td>Therapist behaves in a teacher-like or didactic manner</td>
<td>25.02</td>
</tr>
</tbody>
</table>
ST most characteristic

- Therapist is sensitive to Patient's feelings, attuned to Patient, empathic
- Therapist works collaboratively with the patient (e.g., seeks feedback, checks patient responses in session)
- Therapist uses emotion-focused techniques
- Therapist uses imagery in session
- Therapy focuses on core needs of the patient
- Patient's feelings and perceptions are linked to situations or behavior of the past
- Therapist confronts the patient’s dysfunctional behavior in an empathic way
- Therapist communicates the change process to the patient in terms that they can understand
Other highly discriminative ST

<table>
<thead>
<tr>
<th>Item</th>
<th>F Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist self-discloses</td>
<td>43.63</td>
</tr>
<tr>
<td>Therapist conceptualizes patient’s problems and underlying themes in schema or mode terms</td>
<td>31.82</td>
</tr>
<tr>
<td>Therapist is responsive and affectively involved (e.g., gives extra time if needed)</td>
<td>17.64</td>
</tr>
</tbody>
</table>
PDT most characteristic items

• Therapist is sensitive to Patient's feelings, attuned to Patient, empathic
• Patient achieves a new insight or understanding
• Interruptions or breaks in the treatment, or termination of therapy discussed
• The therapy relationship is a focus of discussion
• Therapist identifies a recurrent theme in Patient's experience or conduct
• Therapist conveys a sense of nonjudgmental acceptance
• Patient's interpersonal relationships are a major theme
Other highly discriminative PDT

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<tr>
<td>Therapist interprets warded-off or unconscious wishes, feelings, or ideas</td>
<td>29.27</td>
</tr>
<tr>
<td>Therapist draws connections between the therapeutic relationship and other relationships</td>
<td>20.65</td>
</tr>
<tr>
<td>Memories or reconstructions of infancy and childhood are topics of discussion</td>
<td>18.16</td>
</tr>
<tr>
<td>Patient's dreams or fantasies are discussed</td>
<td>16.76</td>
</tr>
<tr>
<td>Therapist points out Patient's use of defensive maneuvers (e.g., undoing and denial)</td>
<td>15.23</td>
</tr>
<tr>
<td>Therapist is neutral</td>
<td>14.78</td>
</tr>
</tbody>
</table>
Changes over time (20 years)

• CBT
• PDT
<table>
<thead>
<tr>
<th>PQS item and no.</th>
<th>Mean Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist's remarks are aimed at facilitating Patient's speech</td>
<td>-2.01</td>
</tr>
<tr>
<td>Therapist focuses on Patient's feelings of guilt</td>
<td>-2.03</td>
</tr>
<tr>
<td>Patient achieves a new insight or understanding</td>
<td>-3.11</td>
</tr>
<tr>
<td>Therapist points out Patient's use of defensive maneuvers (e.g., undoing and denial)</td>
<td>-2.03</td>
</tr>
<tr>
<td>Patient's behavior during the hour is reformulated by Therapist in a way not explicitly recognized previously</td>
<td>-2.27</td>
</tr>
<tr>
<td>Therapist communicates with Patient in a clear, coherent style</td>
<td>-2.17</td>
</tr>
<tr>
<td>Patient experiences ambivalent or conflicted feelings about Therapist</td>
<td>-3.13</td>
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</tbody>
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Effectiveness of ST

- 6 outpatient studies (4 RCTs, 1 case series, 1 pilot)
  - 4 individual ST
    - 3 BPD
    - 1 six other PDs
  - 2 group-ST

- Inpatient study  (Reiss et al., 2013)
Initial schema RCT

- SFT superior to Kernberg psychodynamic treatment on all measures (Giesen-Bloo et al., 2006)
- 67% vs 43% clinically significant change
- 45% vs 22% cure
- Drop out rate significantly lower in SFT
- However therapy intensive
Group schema RCT

- Advantages to delivering reparenting in groups.
- Improve connection in a population group that feels innately disconnected.
- 32 patients with BPD in existing treatments assigned to 30 group sessions of SFT or no extra treatment (Farrell et al., 2009)
  - Cure rates, 94% SFT 16% TAU only
GROUP SCHEMA THERAPY MULTI-SITE RANDOMIZED CONTROLLED TRIAL

• Can the effects of so far obtained for schema therapy be replicated in centers that did not develop the treatment.

• Study design – RCT, adequately powered to test group ST vs individual focus vs TAU for BPD (aim 448, to date 334)

• Total of 14 sites - 1 in USA, 2 in Australia, 6 NL, 4 Germany, 1 in UK
Thank you to the generosity of Rotary Health