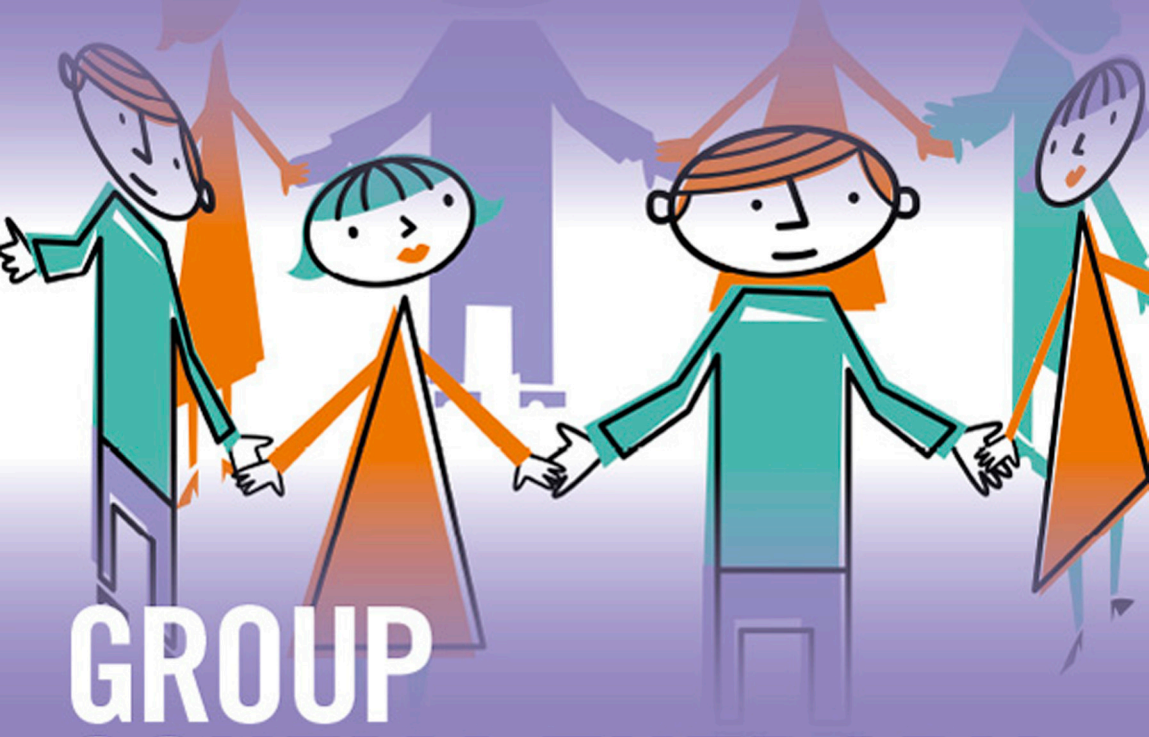

GROUP SCHEMA THERAPY FOR BORDERLINE PERSONALITY DISORDER

A Step-by-Step Treatment Manual with Patient Workbook

JOAN M. FARRELL & IDA A. SHAW

WILEY-BLACKWELL

Group Schema Therapy for Borderline Personality Disorder

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With additional chapters by: Arnoud Arntz, Heather Fretwell, George Lockwood, Poul Perris, Neele Reiss, Hannie van Genderen, Michiel van Vreeswijk and Jeffrey Young

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Foreword

I am very pleased to have been invited to write the foreword for this groundbreaking treatment manual on Group Schema Therapy (GST).

Since I first heard about the extremely positive results of the authors' randomized controlled trial of GST for patients with Borderline Personality Disorder (BPD) in 2008, I have been very excited about the potential of the group model to make schema therapy (ST) more available and affordable for patients. Given the worsening climate for mental health reimbursement in this era of managed care in the United States and elsewhere in the world, GST has the potential to deliver the powerful treatment strategies of the schema approach in a more cost effective manner than has been possible with individual ST – with equivalent or perhaps superior results.

When I met Joan and Ida for the first time at the International Society for Schema Therapy Congress, I was surprised to learn that they had been developing their GST approach for 25 years, and was struck by how many of the core components in my own work they had independently developed for their group approach. GST feels entirely consistent with my own individual model, in terms of the conceptual model, therapeutic alliance, and treatment interventions.

In the past, I had always been skeptical about the possibility of extending the intense therapy relationship I call "Limited Reparenting" – which is so central to the effectiveness of ST – to a group approach. I had always viewed group therapy as a "watered down" version of individual treatment, especially for patients with personality disorders. I was delighted to find that my preconceptions were entirely wrong. The GST approach Joan and Ida have developed is truly unique, exciting, and promising.

GST encourages group members to become like a healthy family in which they can "reparent" each other, under the watchful guidance of two highly

skilled therapist-parents. The sense of belonging and acceptance provided by this group analogue to a loving family seems to catalyze both the limited reparenting and emotion-focused components of ST.

Furthermore, by using two co-therapists for each group, GST has found a way to free up one therapist to move fluidly around the group, often working with one or two members at a time, creating novel experiential exercises to bring about change. At the same time, the second therapist serves as the "stable base" for the rest of the group, maintains an ongoing emotional connection with each member, monitors the reactions of all members, explains what is happening to educate them about what is taking place, and intervenes to shift the direction of the group to focus on the needs of other group members.

I am also impressed that GST goes well beyond traditional Cognitive Behavior Therapy/ Dialectical Behavior Therapy (CBT/DBT) group format, in which members are taught skills in a seminar-like setting; and non-CBT groups, in which the therapist does individual work with one member while the rest of the group primarily watches. In GST, the techniques used in individual ST, such as imagery change work and mode role-plays, have been adapted to engage all of the members in unique exercises that make use of the power of group interaction and support. These group therapeutic factors, combined with the broad range of integrative techniques that are already part of ST, may account for the large treatment effects in the controlled outcome study I mentioned earlier, as well as in preliminary data from other ongoing studies of GST.

This book is the first published treatment manual for GST, and succeeds in providing the most essential information clinicians will need to practice it. The authors describe a systematic approach to treating BPD patients in a group format, while retaining the flexibility that I have always valued so highly in developing individual ST. The treatment suggestions are specific and well-organized, with plenty of examples, while avoiding the temptation to write a therapeutic "cookbook" for therapists to follow in a rote manner.

To be more specific, the authors have preserved the core elements of ST by developing "limited reparenting" intervention strategies for each mode that arises in the group, seizing "experiential moments" to do emotion-focused work that brings about change at a deep level. Like individual ST, their group model blends experiential, cognitive, Interpersonal, and behavioral work.

This manual presents a step-by-step guide for GST with patients who have BPD. It includes a large selection of patient handouts, group exercises, and homework assignments – all presented in downloadable form on the

Wiley website for use with patients. The workbook material is arranged both by mode and by type of intervention, allowing therapists to choose the exercises and homework assignments that best match individual group members, and the therapist's own personal style. The user-friendly format of the book also provides sample therapist scripts, and numerous patient examples throughout.

The experience that the two authors have gained over 30 years of training therapists throughout the world, and leading GST groups with a broad range of clinical populations, is evident throughout the volume. The book is written at a level that should appeal to a very broad range of mental health professionals, including psychologists, social workers, psychiatrists, counselors, psychiatric nurses, as well as interns and residents.

On a more personal level, I had the opportunity to experience GST first hand as a participant at an advanced training workshop that I invited Joan and Ida to teach for the senior schema therapists at our New York institute. I am even more excited about the potential of ST in a group after this experience, and would love to conduct a ST group like this myself once I have learned the necessary skills.

Joan Farrell is an outstanding schema therapist who serves as the "stable base", emotional center, and "educator" for the group as a whole – a role I can imagine myself learning to fill, given enough time and experience. What truly amazed me – perhaps because her style is so different from mine and Joan's – was the remarkable group work of Ida Shaw. It is hard to convey the level of originality, creativity, and spontaneity she brings to the group experience. She is able to blend elements of gestalt, psychodrama, role-playing, and her own infectious style of play into an approach that perfectly fits the intensive demands of schema mode work, cajoling patients to change in profound ways. The group exercises in this manual will allow schema therapists to try out some of her unique work.

I see GST as one of the three most important advances since I began developing ST. It has served as a major impetus for international collaboration to further the development and dissemination of ST, including pilot studies in the Netherlands and Germany, as well as an intensive version for inpatient or day hospital use.

I am especially excited about the large-scale clinical trial that is underway at 14 sites in 5 different countries. Arnoud Arntz and Joan Farrell serve as the co-principal investigators of the study, testing the efficacy and cost-effectiveness of the GST model for BPD patients. This book includes the full treatment manual and patient materials used in the study.

Although this manual focuses on the treatment of patients with BPD, I believe that it also has great potential to be adapted for other patient populations, diagnoses, and treatment settings. Like individual ST, I expect the GST model (based on the principles outlined in this manual) to be effective for patients with other personality disorders (PDs), many Axis I disorders, and other chronic problems that have not responded to existing treatments. GST is already being explored as a potential treatment for patients with eating disorders, Avoidant PD, Dependent PD, Narcissistic PD, and Antisocial PD.

I want to personally thank the many members of the international ST community who have helped Joan and Ida in the refinement of the GST model and handbook. These include: Arnoud Arntz, Hannie van Genderen, and Michiel van Vreeswijk from Holland; Poul Perris in Sweden; Heather Fretwell and George Lockwood in the US; and Neele Reiss from Germany. These individuals have contributed chapters to this book that cover practical issues, such as combining individual and group ST; and more theoretical aspects, such as the chapter on needs and adaptive reparenting. The book also includes a meta-analysis of the studies that have been conducted to evaluate the efficacy of ST for patients with BPD; along with a chapter on the future of the group model, which I co-authored.

I highly recommend this outstanding manual to all mental health professionals working with more complex, chronic, and hard-to-treat patient populations – especially those who are looking for an evidence-based, cost effective alternative to existing therapies. This book is essential reading for professionals interested in ST, BPD and other personality disorders, group therapy, and in new approaches to expanding CBT. I commend Joan and Ida for their willingness to take risks in developing a truly creative and inspiring new approach to ST.

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About the Authors

Joan Farrell, PhD, and Ida Shaw, MA, are the developers of the original Group Schema Therapy (GST) model and have specialized in the treatment of Borderline Personality Disorder (BPD) for 25 years. GST demonstrated its effectiveness in a randomized trial supported by a NIMH grant and was awarded the Governor's Showcase Award in Mental Health, Indiana. They developed an intensive inpatient program on a specialized hospital unit, which has promising pilot results. Currently they are the primary trainers and supervisors for a fourteen-site, five-country trial of GST and Dr. Farrell is co-PI with Professor Arnoud Arntz. Dr. Farrell is the Research and Training Director of the Center for BPD Treatment & Research (CBPDT&R), Indiana University School of Medicine-Midtown Community Mental Health Center, adjunct professor of Psychology, Indiana University-Purdue University Indianapolis. She was a clinical professor in Psychiatry Indiana University School of Medicine for 25 years where she received the Outstanding Faculty Contribution Award from the clinical psychology internship program and was honored by psychiatry residency classes for her teaching and supervision in BPD treatment. Ida Shaw, MA, is an Advanced Level Schema Therapist/Trainer and program consultant for CBPDT&R. She contributes expertise in experiential therapy and developmental psychology to GST. Together they direct the Schema Therapy Institute Midwest, Indianapolis and have been giving training in Schema Therapy (ST) and BPD treatment internationally for 20 years. They have published journal articles, a DVD series demonstrating GST and book chapters on BPD and GST and so far they have provided training to over 350 therapists from 12 countries in GST. They receive outstanding evaluations for their teaching and supervision, including the response that their enthusiasm and demonstrations inspire therapists to begin GST.

Arnoud Arntz, PhD, is a full professor of Clinical Psychology and Experimental Psychopathology at Maastricht University in the Netherlands. He is Scientific Director of the University's Research Institute of Experimental Psychopathology and Director of the Postgraduate Clinical Psychology Program in the south Netherlands. He is associated as a psychotherapist with the Maastricht Community Mental Health Center. He was project leader of the Dutch multi-center trial of individual ST for BPD and is a principal investigator of the current multi-site international trial of GST. He is the honorary scientific and researcher adviser for the International Society of Schema Therapy. He has published numerous articles on cognitive therapy (CT), ST and translational studies related to the mechanism of action of psychotherapy and two books on ST.

Heather Fretwell, MD, is a board-certified psychiatrist. She directs the outpatient BASE (Borderline patients Awareness, Skills, and Empowerment) program Midtown Community Mental Health Center and is Clinical Director of the Center for BPD Treatment and Research of Indiana University School of Medicine, where she is also a faculty member in the department of Psychiatry and lectures to psychiatric residents on personality disorders and psychotherapy. She has trained in Individual and Group ST since 2004 with J. Farrell and I. Shaw, and has presented at international conferences. She is a co-investigator on the international multi-site study on GST for patients with BPD and a principal investigator on the US grant proposals. She conducts ongoing research on the pharmacological and ST treatment of BPD patients. She is a past president of the Indiana Psychiatric Society.

George Lockwood, PhD, clinical psychologist is the Director of the Schema Therapy Institute Midwest and a Founding Fellow of the Academy of Cognitive Therapy. He completed a post doctoral fellowship in CT under the supervision of Aaron T. Beck, MD in 1982, has training in psychoanalytic psychotherapy and object–relations approaches, and has Advanced International Certification in ST. Dr. Lockwood has lectured on CT and ST for 20 years and regularly receives excellent evaluations. He has written a number of articles on both CT and ST, has participated in the development of ST, contributed to "Schema Therapy: A Practitioners Guide", currently is serving on the board of the International Society of Schema Therapy, and has maintained a private practice for the past 25 years.

Poul Perris, MD is the director of the Swedish Institute for CBT & Schema Therapy and a licensed Psychotherapist with an Advanced international Certification in Schema Therapy, trained and supervised by Dr. Jeffrey Young. He is the Founding President of the International Society for Schema Therapy and the current President of the Swedish Association for Cognitive & Behavioral Therapies. He is trained in GST by J. Farrell and I. Shaw and is a member of the treatment protocol board in the international multi-site study on schema group therapy for patients with BPD. He offers ST workshops and supervision internationally. He is part of a research group that focuses on the concepts of core emotional needs and limited reparenting.

Neele Reiss, MSc, PhD (psychotherapist/clinical psychologist), is program director for the inpatient ST ward for patients with BPD at the University Medical Center Mainz, Germany. She holds Advanced international Certification in Schema Therapy, trained and supervised in ST and GST by Jeffrey Young, Joan Farrell, Ida Shaw, Arnoud Arntz and Gitta Jacob. She is a trainer in ST in Germany, Switzerland and the US. She is doing research on intensive ST for patients with BPD, a setting in which individual and group ST are combined. She is the author of journal articles and book chapters in English and German.

Hannie van Genderen, M. Phil. (psychotherapist/clinical psychologist), is employed at the Mental Health Center in Maastricht. She has trained in ST by Dr. Jeffrey Young since 1996. She closely collaborates with Professor A. Arntz of the Maastricht University, with whom she has written the book "Schema Therapy for Borderline Personality Disorder" (Wiley, 2009). She has trained in GST for BPD by J. Farrell and I. Shaw since 2009. She has been a trainer and supervisor in ST in the Netherlands since 2000. She is a member of the board of the International Society of Schema Therapy (coordinator for Training and Certification) and the board of the Dutch Schema Therapy Association.

Michiel van Vreeswijk, PhD, is a clinical psychologist, psychotherapist, cognitive behavioral therapist, supervisor in ST, and co-director at G-kracht private practice, the Netherlands. He is affiliated as a trainer in ST and CBT at several post-doctoral institutes in the Netherlands. He is also affiliated as a trainer with the RINO Group. He regularly gives ST workshops in the UK, Germany and at ISST conferences. He is doing research on GST and is a co-investigator on the international multi-site study on GST for patients with BPD. He is the author of many journal articles in English and Dutch.

Jeffrey Young, PhD, is a clinical psychologist and psychotherapist who is the founder of ST. He directs the Schema Therapy and Cognitive Therapy Institutes of New York. He serves on the faculty in the Department of Psychiatry at Columbia University, is a Founding Fellow of the Academy of Cognitive Therapy, and is co-founder and Honorary President of the International Society for Schema Therapy. Dr. Young has led workshops for over 20 years, training thousands of mental health professionals throughout the world, including the US, Canada, the UK, Europe, Australia, China, South Korea, Japan, New Zealand, Singapore, and South America. He consistently receives outstanding evaluations internationally for his teaching skills, including the prestigious NEEI Mental Health Educator of the Year award. Dr. Young has co-authored two best-selling books with Janet Klosko, PhD: "Schema Therapy: A Practitioner's Guide" for mental health professionals, and "Reinventing Your Life," a self-help book for clients and the general public. Both have been translated into many languages.

Acknowledgments

We first want to acknowledge the Schema Therapy community and ISST who welcomed us with open arms after our presentation at the Coimbra ISST conference in 2008. We formed friendships and collaborations after that meeting, which have significantly affected our careers and lives and led to this book. We thank Arnoud Arntz for his research mentorship, personal support and friendship and Jeff Young for his thought provoking discussions, support and encouragement. Our dear friend and colleague Heather Fretwell bravely dove into the 20 year mass of patient material we had accumulated and began the organization that resulted in the patient workbook of this manual. Neele Reiss, valued collaborator and friend read numerous drafts of this manuscript and worked diligently with Joan on early writing. Poul Perris contributed important experiential exercises and his friendship through the writing process. There are a lot of other people to thank for support and collaboration: Marco Nill, Friederike Vogel, Hannie van Genderen, Gerhard Zarbock (whose cheerleading helped us to finish the book), Wendy Behary, Christoph Fuhrhans, Vartouhi Ohanian, and Klaus Lieb. Gitta Jacob and Eckhard Roediger invited a chapter on GST for their Handbook of Schema Therapy in 2009 that began the writing that led to this book. In addition, we acknowledge our other contributing chapter author Michiel van Vreeswijk and our Wiley editors, Darren Reed and Karen Shields. We heartily thank George Lockwood, who encouraged us to attend the Coimbra meeting, welcomed us into the ST community and invited us to be part of the ST Institute Midwest, which he founded. George has been a support in many ways – reading numerous drafts, being a theoretical sounding board for Joan, offering creative collaboration with Ida and with Julianna offering friendship and hugs.

We offer special thanks to Gerhard Zarbock, and IVAH who produced and funded the DVD set that demonstrates the interventions of this manual.

We thank Vivian Rahn and Nana Novosad who directed and edited the DVDs and the schema therapist "actors", those already mentioned above and Christine Zens, Eva Fassbinder, Niclas Wedemeyer and Brigitte Haaf who played BPD patients (very well). We also acknowledge the grant support we have received in the course of developing and evaluating GST: National Institute of Mental Health, Association for the Advancement of Mental Health Research of Drs. Joyce and Iver Small, the Clarian Values Grant. We thank the early supporters of our work who were willing to take on the paradigm shifts and opposition encountered in implementing a new way to work with BPD patients: Diana Haugh, John Mitchell, Jeffrey Kellams, Alan Schmetzer and Vicki Silver.

The therapists who trained with us have made important contributions to this treatment manual as teaching forced us to make explicit and clear the way we practice group schema therapy. They have also shared their creative ideas and feedback that led to improvements in our training model. Most of all we thank our patients, who taught us what we needed to understand about their needs and struggles and what worked to help them – the creative, intense, talented and at times challenging group of people with Borderline Personality Disorder. They stuck with us through the "group from Hell" when we were first testing our treatment ideas and continued to trust us through the 27 years of our developing the approach presented in this book. This treatment manual is dedicated to them.

Joan Farrell & Ida Shaw

1

Introduction

J. M. Farrell and I. A. Shaw

This manual presents a step-by-step guide for Group Schema Therapy (GST) with patients who have Borderline Personality Disorder (BPD) along with a collection of handouts, group exercises, and homework to use with patients. It is the result of 25 years of work by Farrell and Shaw to develop an effective and comprehensive psychotherapeutic treatment for this group of severely disabled patients whose potential is tragically not realized in the quality of their lives. The authors' collaboration combined the training of Farrell in cognitive, personal construct, social learning, and psychodynamic treatment approaches with Shaw's training in developmental psychology and experiential approaches such as Gestalt therapy and bioenergetics into an integrative model for group therapy of BPD. Their initial approach was based upon their observation that BPD patients did not easily fit into traditional psychotherapy. For example, the patients they were working with were too distressed to stay in an office attending to the session for 50 minutes – they either dissociated or fled. In an effort to address this therapy-interfering behavior, Farrell and Shaw set distress reduction as the first goal. Patients were able to reduce distress enough to stay in sessions, but they did not use these techniques outside of sessions. This was understood as an inability to recognize pre-crisis distress levels – the point at which it is possible to use distress reduction most effectively. At the same time, Lane and Schwartz (1987) published an article presenting their theory of "levels of emotional awareness", which they postulated as being parallel to Piagetian levels of cognitive development. This theory fit with the clinical observation

Group Schema Therapy for Borderline Personality Disorder: A Step-by-Step Treatment Manual with Patient Workbook, First Edition. By Joan M. Farrell and Ida A. Shaw.

of BPD patients, who presented at early levels of emotional awareness – at best the global level where emotion is experienced as global extremes of good and bad. This construct parallels the dichotomous thinking observed in BPD. So, Farrell and Shaw's second treatment goal became increasing the level of emotional awareness patients had so that they could recognize pre-crisis distress. Accomplishing this required the use of experiential techniques including some at the level of kinesthetic awareness. Awareness work is consistent with Schema Therapy (ST) and remains part of the treatment described in this manual. Unfortunately, Farrell and Shaw found that even after their patients were able to notice pre-crisis distress, outside of therapy they still did not use the distress management or coping strategies they had been taught. Using a practical and collaborative approach, they asked the patients "Why?." The answer gave them the third goal of their initial program – schema change. Patient's answers were some form of "I am bad and deserve punishment, so it would be wrong to do good things for myself" or "I am helpless and life is hopeless, so why try?."

At about this point, Jeffrey Young's first book was published (1990). It became clear to Farrell and Shaw that someone else was struggling with the same dilemmas as they were with BPD patients and attempting to match treatment to the patient rather than vice versa. They identified the similarities in the theoretical model and the effort to integrate cognitive, behavioral, and experiential interventions in what Young was calling schema-focused therapy. Although they were not using the term, their approach had a limited reparenting focus from the beginning as they identified deficits in early emotional learning and failed attachment in BPD patients and the need to adapt traditional psychotherapy to deal with such deficits. The first name for their group work was "emotional awareness training" and they published an article describing it in the first issue of *Cognitive and Behavioral Practice* (Farrell and Shaw, 1994).

The first BPD treatment program that Farrell and Shaw wrote a manual for had three goals for patients: (1) to develop an individualized distress management and self-soothing plan and be able to use it effectively); (2) be able to recognize pre-crisis levels of distress and take action at that point; and (3) be free enough of maladaptive schemas to be able to take the actions of goals (1) and (2). The third goal was the most challenging as, like Young (1990), they used a definition of maladaptive schema that required change at not only the cognitive level, but also the emotional level. The original group treatment program consisted of 30 once-a-week, 90-minute group sessions designed to be an adjunct to individual psychotherapy. This

program was tested in a randomized controlled trial (RCT) supported by a National Institute of Mental Health (NIMH) grant that compared treatment as usual (TAU) individual psychotherapy (not ST, rather cognitive behavioral therapy [CBT] or psychodynamic) to TAU plus GST. The trial was conducted from 1991 to 1995 and is reported in Farrell, Shaw and Webber (2009). All patients were required to have been in their individual psychotherapy relationship (TAU) for at least six months, and stay in it for the course of the study and the six-month follow-up period. So essentially patients all received at least 20 months of weekly individual psychotherapy and half of them had the additional 30-session group program. The results (which are described in more detail by Arntz in Chapter 12: Systematic Review of Schema Therapy for BPD) demonstrated some of the largest treatment effect sizes published for a psychotherapy study.

The next development in the GST model occurred when a colleague, (Fretwell, a joint author of Chapter 10 in this book, who was a psychiatric resident with Farrell as a psychotherapy supervisor) attended a workshop with Young in 2003, and brought back information about a theoretical advance in ST – the schema mode. Modes are defined as the current emotional, cognitive, and behavioral state a person is in. The addition of the mode concept further integrated emotion into the understanding and treatment of patients with BPD. The idea that schema modes are triggered by events that patients experience as highly emotional and that modes can switch rapidly, resulting in the sudden changes in behavior or seemingly disproportionate reactions that plague BPD patients, aids both therapists and patients in understanding their experience and how to work toward change during therapy. The mode model captures the symptoms of BPD in user-friendly, understandable language for patients. Identifying the mode a patient is in also provides the foci for the type of therapist response required (e.g. validation versus empathic confrontation or limit setting). The mode concept was particularly important for psychotherapy with BPD patients who have high endorsement of almost all 18 maladaptive schemas. To focus instead on four or five modes is less overwhelming for both patient and therapist. Farrell and Shaw quickly incorporated this innovation by Young into their group work where it was particularly helpful as they moved on to develop an intensive version of the GST program for patients with severe BPD in inpatient settings. The intensive program incorporated the schema mode model for BPD of Young et al. (2003) adapted for group delivery. Uncontrolled pilot trials on an all-BPD inpatient unit demonstrated large treatment effect sizes for this longer program (Reiss, Lieb, Arntz, Shaw and

Farrell, in press). The original intensive model provided 10 hours of GST and one hour of ST per week with the average length of stay 18 weeks, thus a total of 180 hours of group and 18 hours' individual therapy. This is approximately equivalent to a year of outpatient treatment: two hours of GST per week with 18 individual sessions over a year. Whether GST delivered in a massed format in inpatient or day therapy, or over a year in traditional outpatient psychotherapy, is a question yet to be determined.

By the time they met Young and Lockwood in 2006, Farrell and Shaw realized that what they had developed was a group version of ST. In 2008, with Fretwell, they presented the results of their outpatient RCT and inpatient pilot study at the International Society of Schema Therapy (ISST) annual congress (Farrell, Fretwell and Shaw (2008). That presentation connected them with Arntz, who was planning a trial of ST in a group format. This resulted in a collaboration on the development of an international multi-site trial of Farrell and Shaw's model of GST in five countries at 14 sites with 448 BPD patients. This treatment manual is also the result of the ISST congress, where a work group was formed to produce a treatment protocol for the study chaired by Farrell, with Shaw and other senior schema therapists from four countries: the Netherlands – Arnoud Arntz, Hannie van Genderen, Michiel van Vreeswijk; Sweden – Poul Perris; USA – Heather Fretwell, George Lockwood and Jeffrey Young; and Germany – Neele Reiss.

The production of the treatment protocol and this book began by Farrell and Shaw sharing the original group model and manual (Farrell and Shaw, 1994; Farrell et al., 2009) with the work group. Using the work group's feedback from reviewing written drafts and observing demonstrations of GST in their training workshops, an extensive outline of the goals, stages, and therapist tasks of GST was developed. These outlines were tremendously helpful in the process of Farrell and Shaw's attempt to make explicit for the manual their practice of GST, which after 25 years of practice is implicit to the way they do GST. The work group contributed additional chapters from their areas of expertise in ST to produce a comprehensive treatment manual for GST. We benefited greatly from discussions with Jeff Young and his generous input about the adaptation of ST for group. George Lockwood and Neele Reiss were tireless in their editing of numerous drafts. Arnoud Arntz, as usual, was a great support in all ways. The process of writing this manual reflects the overarching collaborative and integrative style of ST as an approach to psychotherapy and life.

The Challenge of Producing a Manual that Represents the Flexibility of Schema Therapy

An essential feature of the practice of Schema Therapy is that the therapist intervention match the mode the patient is in. This requires a good deal of flexibility on the part of the schema therapist in contrast to more regimented, skills training approaches such as Dialectical Behavior Therapy (DBT). Conducting ST in a group requires even more flexibility, as one is trying to match the modes of eight people and a ninth "person" – the group as a whole. In addition, the group therapist must harness the unique therapeutic factors of groups that are hypothesized to augment or catalyze the active ingredients of ST (Farrell et al., 2009) and to master the additional challenges the group modality presents. These critical elements require that a treatment manual and the patient materials for GST must be flexible and allow for matching the combination of modes that the group is in from moment to moment. In contrast, patients with BPD have typically grown up with the normal childhood need for predictability, supportive structure, and safety not being met. So, in addition to flexibility and seizing opportunities to make use of the healing aspects of group process, an effective ST group for BPD patients needs some amount of structure and predictability. The next requirement for a GST manual is that it provides enough structure and information so therapists using it can meet adherence requirements. Adherence is critical to being able to empirically validate a treatment in research trials. Adherence to a model is also what allows the positive results of the originators to be replicated in clinical settings. With the help of some of the senior schema therapists in the world, we have attempted to meet all of these challenges and requirements in this manual. Our plan is to have a manual that provides enough structure and predictability for patients to feel safe and for adequate adherence in treatment delivery to be possible, that also provides for the need to match intervention to group modes and attend to the group's process and opportunities to harness its therapeutic factors.

The Manual Chapters

The "how to" part of the manual begins with a brief description of ST, what remains the same in GST and what changes when ST is carried out in a

group. This includes a discussion of the adaptations to limited reparenting that the group model requires and Farrell and Shaw's development of the co-therapist team model for BPD treatment, adapting technique from individual ST to the group, descriptions of which interventions to use for each of the most frequent BPD modes, and how to take into consideration the stage of the group. The first nine chapters by Farrell and Shaw are intended to provide you with a step-by-step guide for conducting GST. This section is complimented by the patient materials available online.

The patient materials accompanying the manual (Chapter 9) were chosen from the 20+ year collection of material originally developed by Farrell and Shaw. All of the patient material has been tested in BPD patient groups and modified and refined based upon their responses and input and post-group discussions. It is being used as the protocol for the international multi-site trial of GST that is currently being conducted in the Netherlands, Germany, the US, Scotland and Australia at 14 separate sites. Therapists will be able to choose from the exercises, handouts, and homework of the manual based upon the goal they are focusing on, the assignments and exercises that best fit the mode of their group, and the stage of treatment that the group is in. Patients can assemble the material selected for them into a workbook that will be unique to their ST group. Practitioners new to ST can follow closely the recommended session order with corresponding patient materials, while experienced schema therapists can create their own order of preference. Cognitive therapists can try out the experiential exercises provided and experiential therapists can make use of the cognitive and behavioral techniques also provided in the manual. Group therapists with no ST training can explore the ST conceptual model and try out the group exercises developed for and tested on BPD patients.

Chapters 10 through 13 address other important applications and issues of GST. In Chapter 10 the issues involved in combining individual and group schema therapy are discussed with case examples by van Genderen, Lockwood, van Vreeswijk, Farrell, and Reiss. Peer supervision is included in this chapter given the important role of a team approach to the coordination of the two modalities. Chapter 11 by Perris and Lockwood addresses the use of emotional need as a compass for adaptive reparenting interventions by schema therapists. They take the mode matching axiom of ST even further with practical descriptions of what adaptive reparenting looks like based upon schema and need domain. The acknowledged leader of ST research, Arntz, describes the effectiveness of research for GST in Chapter 12.

Keep in mind that this manual addresses the GST treatment needed for BPD patients. The various techniques and the reparenting style described in this manual address the modes, underlying needs, and developmental level of BPD patients at various stages in an 18- to 24-month treatment process. They will fit patients who are similar on those three dimensions, whether they have a BPD diagnosis or not. Patients with different disorders will have different sets of needs at various developmental levels, and GST can be adjusted accordingly. An underlying axiom of all ST is that the intervention must match the patient and their mode. A healthier and more functional patient group may need a group of peers in which much of the reparenting is done by the group itself, with guidance from one therapist, rather than a "surrogate family" with two parent–therapists leading it. In Chapter 13, Reiss, Farrell, Arntz and Young discuss the application of the GST model to other patient groups and what they see as the future of GST.

Young has described GST as a third stage in the development of ST (Roediger, 2008). This third stage is not only an innovation with respect to ST content, but also has been a major impetus for international collaboration for the further development and dissemination of ST. The group model of ST holds important promise with the public health dilemma of our time – a way to make an evidence-based treatment widely available for BPD (and potentially other severe disorders). Like individual ST, we expect the group ST model developed by Farrell and Shaw to be adapted effectively for other PDs and Axis I disorders and chronic problems that have not responded to other treatments.

2

The Conceptual Model of Group Schema Therapy

Joan M. Farrell and Ida A. Shaw

The Group Schema Therapy (GST) model presented in this manual is consistent with the theory, components of treatment, and goals outlined for individual Schema Therapy (ST) by Young, Klosko & Weishaar (2003) and the Arntz & van Genderen (2009) publication of the treatment protocol from the successful trial in the Netherlands (Giesen-Bloo et al., 2006). Schema Therapy's conceptual model for Borderline Personality Disorder (BPD) will be briefly summarized here and the reader is referred to those volumes for additional elaboration of the individual ST model and its application. ST is an integrative treatment with roots in Cognitive Therapy (CT), learning theory, and the research of developmental psychology. ST grew out of efforts by Young and associates to treat more effectively patients with personality disorders and those who either did not respond to traditional CT or relapsed. As the name suggests, the focus of ST is at the schema level. This requires a shift from present-day issues to lifelong patterns, an adaptation required for personality disorder work. ST is based upon a unifying theory and a structured and systematic approach. ST concepts have some overlap with CT, psychodynamic psychotherapy, object relations theory, and Gestalt psychotherapy, but they also differ in important respects and have total overlap with no other model. The goals of ST reach beyond teaching behavioral skills, including the fundamental work of personality change. This change is conceptualized as involving decreasing the intensity of maladaptive schemas that trigger under- or over-modulated emotion and action states referred to as modes. The triggering of these intense states is seen as interfering with the use of adaptive coping or interpersonal skills by

Group Schema Therapy for Borderline Personality Disorder: A Step-by-Step Treatment Manual with Patient Workbook, First Edition. By Joan M. Farrell and Ida A. Shaw.

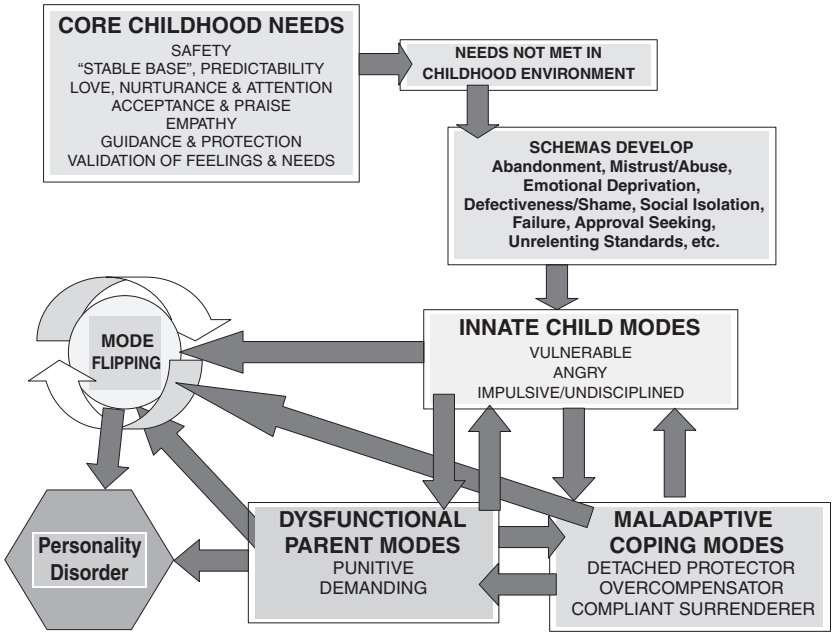

Figure 2.1 Schema therapy model. Etiology of personality disorder

patients that would allow them to realize their potential and improve their quality of life.

Schema Therapy's Hypothesized Etiology of BPD

Figure 2.1 summarizes the model for the etiology of BPD posited by ST. When the normal, healthy developmental needs of childhood are not met, maladaptive schemas develop. Maladaptive *schemas* are psychological constructs that include beliefs that we have about ourselves, the world, and other people, which result from interactions of unmet core childhood needs, innate temperament, and early environment. They are composed of memories, bodily sensations, emotions, and cognitions that originate in childhood and are elaborated through a person's lifetime. These schemas often have an adaptive role in childhood (e.g., in terms of survival in an abusive situation – it engenders more hope for a child if they believe they are defective as opposed to the adult being defective). By adulthood, maladaptive schemas are inaccurate, dysfunctional, and limiting, although strongly held and frequently not in the person's conscious awareness. Nineteen early maladaptive schemas (EMS) were identified in patients with personality disorders (Young, 1990; Young et al., 2003). The original 15 are organized

Table 2.1 Schemas organized by content area

Disconnection and Rejection (Connection and acceptance)	**Impaired autonomy and performance (Autonomy and performance)**
Mistrust/abuse	Dependence/incompetence
Emotional deprivation	Vulnerability to harm/illness
Defectiveness /shame	Enmeshment/undeveloped self
Social isolation/alienation	Abandonment/instability
Emotional inhibition	Subjugation
	Failure
Impaired limits (Adequate limits)	**Exaggerated expectations (Realistic expectations)**
Entitlement	Self-sacrifice
Insufficient Self-Control	Unrelenting standards

around four content areas: I Disconnection and rejection; II Impaired autonomy and performance; III Impaired limits; IV Exaggerated expectations. The three which were added more recently – negativity, punitiveness, and approval seeking – are not included in the table as there is not yet an empirical basis for placement or their existence as separate factors.

When maladaptive schemas are triggered, intense states occur that are described in ST as "schema modes." A schema mode is defined as the current emotional, cognitive, and behavioral state that a person is in. Dysfunctional modes occur most frequently when multiple maladaptive schemas are triggered. Four basic categories of modes are defined (Table 2.2).

Primary **Child modes** (Vulnerable Child, Angry Child, Impulsive Child) are said to develop when basic emotional needs in childhood (such as safety, nurturance, or autonomy) are not adequately met. These innate "child modes" are defined by intense feelings such as fear, helplessness, or rage, and involve the innate reactions a child has. **Dysfunctional Parent modes** (Punitive Parent or Demanding Parent) comprise the second category of modes. Dysfunctional Parent modes reflect the internalization of negative aspects of attachment figures (e.g., parents, teachers, peers) during childhood and adolescence. Labeling these modes "parent" is not intended to blame parents for BPD symptoms. Parents have their own schema and mode issues and may have deficits in the parenting they experienced and, consequently, impaired parenting ability. According to a review by Zanarini &

Table 2.2 Schema modes, their role in BPD, relationship to BPD symptoms

	Role in BPD	*Related BPD Symptoms*
Child modes		
Vulnerable Child Experiences intense feelings, emotional pain and fear, which become overwhelming and leads to flips into Maladaptive Coping modes that are identified as other BPD symptoms	Intense, uncomfortable feelings – emotional pain and fear become overwhelming and lead to flips into Maladaptive Coping modes that are identified as BPD symptoms	Abandonment fears, real or imagined
Angry Child Vents anger directly in response to perceived unmet core needs or unfair treatment	A source of problems with others since anger is not just about present trigger, it is seen as inappropriate and misunderstood	Intense inappropriate anger Stormy relationships Emotional reactivity
Impulsive Child Impulsively acts based on immediate desires for pleasure, without regard to limits or other's needs (not related to core needs)	Also a source of interpersonal, work, legal problems. Action is usually self-damaging or potentially so	Difficulty controlling anger Self-injury Impulsivity that is potentially self-damaging Unstable sense of self
Maladaptive Coping modes		
Avoidance Pushes others away, breaks connections, emotional withdrawal, isolates, avoids	Most common in a continuum from "spacy" to severe dissociation or physical withdrawal. Can be in the form of pushing others away via anger – the Angry Protector	Emptiness Dissociation Unstable identity

(*Continued*)

Table 2.2 (*Continued*)

	Role in BPD	*BPD Symptoms*
Overcompensation Coping style of counterattack and control. Sometimes semi-adaptive	Common – Bully-Attack mode	Intense inappropriate anger Difficulty controlling anger
Surrender Compliance and dependence – gives up own needs for others, people pleasing	Common and often overlooked as can flip quickly to overcompensation	Unstable sense of self Emptiness
Dysfunctional "Parent" Modes		
Punitive Restricts, criticizes and punishes self and others	Very common, can be a source of self-injury or suicide attempts	Suicide gestures or attempts
Demanding Sets high expectations and level of responsibility, pressures self/others to achieve	Common also, origin of defectiveness, unstable sense of self	Suicide gestures or attempts Unstable sense of self
Healthy modes		
Adult Is able to meet needs in healthy way	Underdeveloped	Unstable identity Emptiness
Happy Child Feels loved, connected, content	Often non-existent	Unstable identity Emptiness,
Mode flipping		
Frequent, exhausting, feels "crazy" and confusing to self and others	Can account for instability affect, behavior, interpersonal, identity Transient psychosis	Emotional reactivity Unstable identity Stress-related psychotic states