Schema Therapy

Outline of model
- Developed by J. Young in 90’s to treat entrenched, chronic, “treatment resistant” problems presumed to have significant origins in childhood/adolescence - for example, personality disorders; complex trauma reactions; chronic depression and anxiety
- Integrates cognitive, behavioural, attachment, gestalt and psychodynamic theory and ideas

Broad goal of schema therapy
- To help patients get their “core needs” met in a healthy and adaptive manner
- To develop/strengthen the patient’s “healthy adult” – who enjoys life; takes appropriate responsibility; makes healthy decisions; maintains healthy relationships; respects self and others; no longer is a ‘victim’; expresses emotion healthily

Core childhood needs
Safety - children need to be able to depend on a reliable adult
Connection to others - children need to be able to share their experiences, thoughts and feelings
Autonomy - children must have a safe, secure environment from where they can experience and learn about the world and eventually be able to stand on their own two feet
Self-appreciation - Children must be helped to appreciate themselves in order to develop good self esteem
Self-expression - children need to be able to express their opinions and feelings without being held back or restrained or punished
Realistic limits - children need to be helped to understand societal rules in order to be able to live in harmony with others; they also need to be helped to develop strategies for dealing with frustrations

When these needs are not met:
Dysfunctional schemas and coping strategies develop - see below*

*Schemas and Modes
Schemas – “life patterns” - usually originate in childhood/adolescence; in our patients they are dysfunctional to a significant degree. Common ‘domains’: Disconnection & Rejection; Impaired Autonomy & Performance; Impaired Limits; Other directedness; Over vigilance & Inhibition

Modes - Our current moment to moment emotional state and coping; schema therapy identifies child modes, dysfunctional coping modes, dysfunctional parent modes; they usually involve:
- Fight - trying to make the schema not true (e.g. you WON'T leave me!)
- Flight - trying to escape the schema (e.g. I’ll drink to block it out), or
- Freeze – ‘giving in’ to the schema (e.g. I can’t escape, you might as well hurt me)

Patient Examples

Borderline Personality Disorder (Cluster 8)
These patients often experience sexual, physical or emotional abuse & struggle to tolerate emotions without engaging in self destructive behaviours; they often have a ‘disorganised attachment style’ meaning they display confused & inconsistent attempts at getting their needs met
- Unmet childhood needs – most if not all of them
  - Schemas – abandonment/instability (you’ll leave me); emotional deprivation (no one cares about me or understands me); defectiveness/shame (I’m worthless/no good)
  - Modes – vulnerable child (please don’t leave me I’m scared); angry child (I hate you I’m going to kill myself); detached protector (I’m fine; I feel nothing); punitive parent (I’m useless, I’m wasting your time)
  - Goals of therapy - To care for own needs; to articulate emotion healthily; to tolerate frustration & distress; to develop realistic expectations of others; to react flexibly to difficult situations

Dependent Personality Disorder (Cluster 7)
These patients often come from enmeshed families who undermine their children's confidence, are overprotective, or fail to reinforce competence/success; they struggle with appropriate independence/decision making etc.
- Unmet childhood needs – autonomy; self-expression; self-appreciation
  - Schemas – dependence/incompetence (I am incompetent and need to depend on others); enmeshment/underdeveloped self (emptiness; don’t know who I am); defectiveness/shame (I’m no good on my own)
  - Modes – vulnerable child (please don’t leave me); dependent child (help me, I can’t cope); compliant surrenderer (I’ll do whatever you tell me to do)
  - Goals of therapy - To care for own needs; to develop autonomy and confidence in own ability to cope with life; to develop a stronger sense of self; to develop self esteem

Evidence Base
Giesen-Bloo, J. et al; 2006 - Outpatient Psychotherapy for Borderline Personality Disorder: Randomised Clinical Trial of Schema Focussed Therapy vs. Transference Focussed Therapy. Archives of General Psychiatry, 63, 649-58: 4 years after start of treatment, 52% recovered from BPD; +2/3rds showed clinically significant improvement in in reducing BPD symptoms (dropouts were included in the study). Most compelling results: All BPD problems were reduced and not only conspicuous symptoms such as self-injury.
Nordahl, H.M & Nyaaseter, T.E.; 2005 - Schema Therapy for Patients with BPD: A single Case Series. Journal of Behaviour Therapy & Experimental Psychiatry, 36(3), 254-64 - 50% of patients no longer met the criteria for BPD and 80% appeared to have "notably profited from the treatment"