Treating the Trauma: Applications of Schema Therapy to offence focused interventions

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Who is in the room?

Schema Therapy

Integrated Theoretical Approach	• Best described as emotion focused interpersonal therapy • Has cognitive and behavioural elements
Developed for PD, applicable to those with trauma history	• Childhood experiences key to understanding current problems • Developing evidence in multiple populations
Key Principles	• Limited re-parenting • Empathic confrontation • Experientially focused • Schema Chemistry

Domains & childhood experience

Disconnection & Rejection	*Abusive, traumatic childhoods, unstable family life, Experienced rejection and humiliation, feel different and in some way, long periods of insecurity and inconsistent parenting*
Impaired Autonomy & Performance	*Often over protected and controlled as Children, or neglected and ignored, left alone with no interest shown in their lives, continually undermined and made to feel incompetent, or were encouraged to be dependent on others*
Impaired Limits	*Have not developed an internal sense of control, difficulty respecting the rights of others, families were very Un-boundaried children did not have rules*
Other Directedness	*Experienced conditional love (i.e. I will love you only if…), family overly concerned with appearances, parents focussed on their own needs*
Over-vigilance and Inhibition	*Strict control by parents to gain compliance, learned to be watching all the time waiting for bad things to happen, frightened to express feelings, severe punishments*

Schemas & Domains

Disconnection & Rejection	**Abandonment/Instability** **Mistrust/Abuse** **Emotional Deprivation** **Defectiveness/Shame** **Social Isolation/Alienation**
Impaired Autonomy & Performance	**Dependence/Incompetence** **Vulnerability to Harm** **Enmeshment** **Failure**
Impaired Limits	**Entitlement** **Insufficient Self Control/Self Discipline**
Other Directedness	**Subjugation** **Self-Sacrifice** **Approval Seeking/Recognition Seeking**
Over-vigilance and Inhibition	**Negativity/Pessimism** **Emotional Inhibition** **Unrelenting standards/** **Hyper criticalness/Punitiveness**

Schema Chemistry

- Developments in the field of interpersonal neurobiology, suggest that our personal relationships affect the way the mind builds neural pathways.

- Emotional memories—of a parent adored or feared, of a partner loved or lost—create pathways in the limbic part of the brain. Every time you revisit those memories, positive or negative, you reinforce the path, deepening a trench of emotional connection.

- **Schema Chemistry** is the almost irresistible pull towards those who remind you of past attachments; decisions that feel like choices are actually automatic responses guided by the map of your past

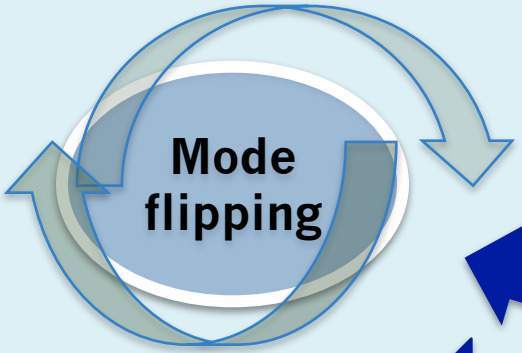
Core childhood needs

Being safe
Stable and predictable environment
Love, nurture ad attention
Acceptance, praise and empathy
Guidance and protection
Validation of feelings and needs

Needs not met in childhood

Schemas develop

Abandonment, defectiveness shame, emotional deprivation, failure, approval seeking ,etc..



Child Modes

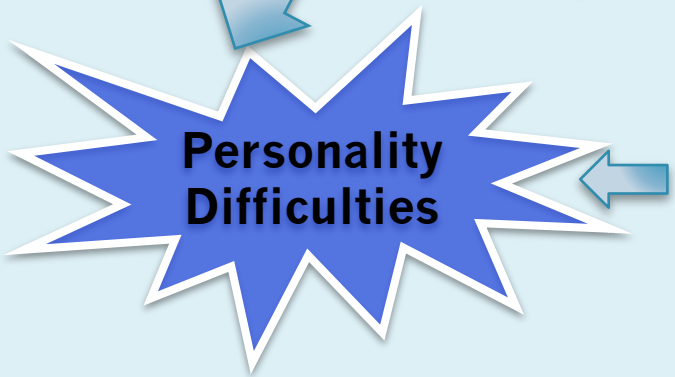
Vulnerable, Angry, Impulsive, Lonely

Maladaptive Coping Modes

Detached protector, Over compensator, compliant surrender

Dysfunctional Parent Modes

Critical, Punitive, demanding



CHILD MODES – All children are born with the ability to develop child modes. They usually represent a persons unmet needs in childhood and so are made up of our core schemas (except the happy child mode).

MALADAPTIVE COPING MODES – These represent the patterns/styles of coping that we develop to cope with the emotional distress felt by the child modes. These are usually the modes that are worked on in therapy as they serve to keep the schemas in the child modes strong.

PARENT MODES – When the person is in a parent mode, they become like their parent (s). These modes inflict the same kinds of experiences on the child mode that their parents did upon them.

HEALTHY ADULT - This mode is the healthy, adult part of the person that helps meet the child's basic emotional needs. The Healthy Adult nurtures and protects the vulnerable child, set limits for the paranoid/ angry child and battles or moderates the maladaptive coping and dysfunctional parent modes.

Vulnerable Child Mode

Angry Child Mode

In this mode, the person expresses uncontrolled anger but no deliberate intention to hurt others.

Parent Modes

Parent modes often show up in our self talk and contain early messages we received from other people. These modes can makes us feel unworthy and ashamed (through devaluing and denigrating messages which is called the punitive parent mode). They may come up if we feel exposed or vulnerable. Our parent modes can also put pressure on us to avoid mistakes and achieve/succeed at all costs (demanding parent mode).

Coping Modes

Compensation Modes

(FIGHT)

Avoidance Modes

(FLIGHT)

Surrender Modes

(FREEZE)

The Avoidant/Protector Coping Modes

Compliant Surrender Mode

- When someone is in an Surrendering Coping Mode they care about the needs of others and not at all about their own.

- They allow others to treat them badly and do things they actually do not want to do because others want or demand it even though objectively they are not obliged to do so.

Overcompensation Modes

- People usually develop ways of coping through overcompensation to cope with feelings of loneliness, helplessness, inferiority or threat.

- Typical over-compensatory behaviour patters include;
  - Narcissistic arrogance (present as superior and contemptuous). People with this style of overcompensating might fanstise about being rich, famous, important or successful.
  - Obsessive Control (insist on telling others what to do and taking control)
  - Aggression (physical violence and/or verbal intimidation). Aggressive overcompensation is typical of people who have experienced severe violence and threat in their past)
  - Cheating and Cunning (manipulate others to enforce own interests). This is typical of people who grew up in very insecure environments.

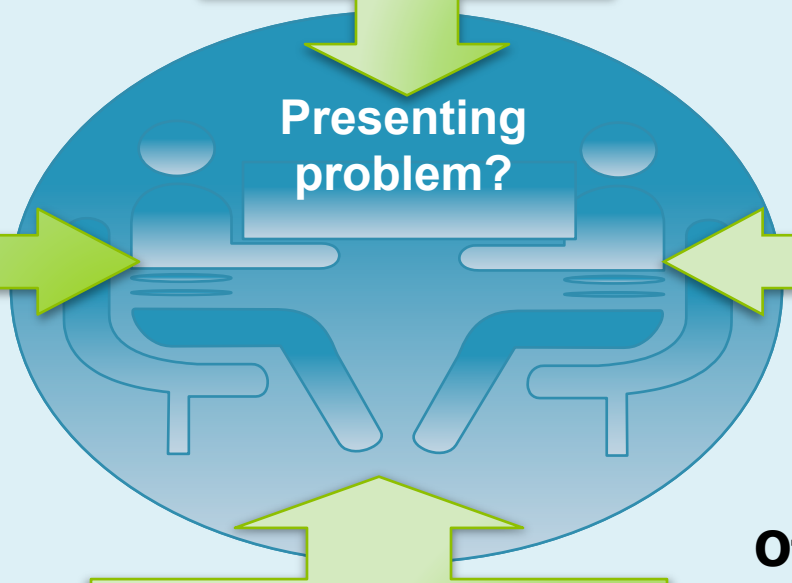
Shengold (1989)

Soul murder is the apparently wilful abuse and neglect of children by adults that are of sufficient intensity and frequency to be traumatic. The child's subsequent emotional development has been profoundly and predominantly negatively affected; what has happened to them has dominated their motivating unconscious fantasies; and they have become subject to the compulsion to repeat the cruelty, violence, neglect, hatred, seduction, and rape of their injurious past.

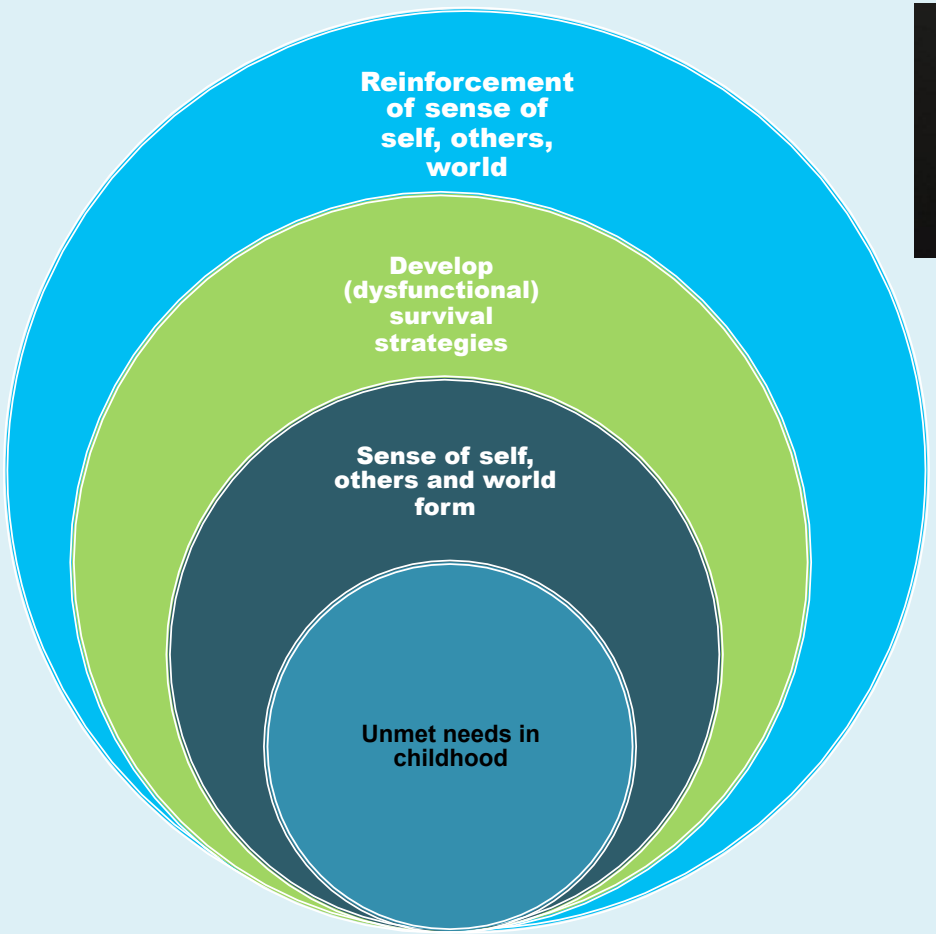
Imagery Exercise

Key Therapeutic Strategies

Forensic Schema Formulation



Schema Formulation as Linking Framework



Example Formulation

Mr B describes an early childhood characterised by physical, emotional and sexual harm, and repeated experience of rejection. He views himself fundamentally flawed, unlovable, (Defectiveness/Shame), and unable to fit in to peer groups or the wider society (Social Isolation). His view of others was that they would either hurt or reject him in some way, and not consider his needs as important (Mistrust/Abuse, Abandonment/Instability, Emotional Deprivation). These are the core features of his *Vulnerable Child Mode*, the part of himself that represents his unmet emotional needs. He internalised these experiences of childhood, and developed a powerful self-critic, conceptualised as the *Punitive Parent Mode*. This mode interacts with the Vulnerable Child mode, reinforcing his core schemas, and mirroring messages he received in childhood. Mr B lacked the necessary experience in emotional self-regulation, and his behaviour resulted in restriction, punishment and rejection. He becomes angry and frustrated when he perceives his is being treated unfairly (*Angry Child Mode*) which is evidenced through threats that may lack intention to act, but serve to communicate a sense of being disregarded or mistreated. He developed the capacity to emotionally disconnect from a young age in order to survive adversity (*Detached Protector Mode*). Mr B can present as avoidant of his emotions, and it is hypothesised that his is able to remain in this mode whilst in custody, hence his apparent stability. Alcohol historically served as a mechanism to disconnect from traumatic memories and associated emotions. Mr B describes a relational pattern of trying hard to please others, but this resulting in ultimately being hurt and rejected (*Compliant Surrender Mode*), reinforcing his view of self and others.

Mr B has used compensatory behaviours such as violence, control and threats, (*Paranoid Overcontroller Mode*) which have similarly functioned as an attempt to avoid being hurt or abandoned, but have been equally ineffective in achieving this. Mr B has targeted other individuals (*Bully Attack Mode*), as a means of channelling the distress and anger associated with perceived harm or threat. Whilst in this mode, Mr B likely felt powerful and in control, in contrast to how he feels in life generally. Mr B has maintained that the non-contact offences were motivated by his anger regarding past abuse, thus associated with this mode. An alternative formulation is that his sexual offending was motivated by sexual interest, serving to provide an opportunity for emotional self-soothing and sexual gratification in the context of a failing relationship where Mr B felt unloved, worthless and isolated. His daughter was not in a position to reject Mr B, and viewing, downloading and distributing images provided a secret world where he could feel connected to others with like-minded interests and without fear of rejection if he engaged in similar activities (*Detached Self Soother*). This hypothesis would consider Mr B's denial and alternative narrative of motive to serve as a mechanism to protect him from overwhelming shame and self-loathing. Mr B has a reasonably developed *Healthy Adult Mode*. When in this mode, Mr B is able to place limits on his avoidant/compensatory modes in custody, and engage in activities and occupation that provide him with a degree of self-worth and serve to weaken his core schemas. Employment has been a particular strength for Mr B. I would consider him to have a genuine motivation to engage in change focused work, but he would require specialist intervention from a skilled and experienced therapist to be able to navigate a trauma focused intervention, prior to a more specific focus on his offending behaviour.

Key Relational Strategies

- **Empathic Confrontation** – Expressing understanding of the reasons that the person perpetuates whilst simultaneously confronting the necessity for change.

- **Limited Re-parenting** –providing within appropriate boundaries of the therapy relationship what the patients need but did not get from their parents as children – partial antidote to EMS.

Imagery Re-scripting

- Neutralising negatives or developing positives
- Aim is to alter the person's emotional relationship with the memory
- Can involve:
  - Manipulating image (size, colour, volume)
  - Changing interpersonal dynamics and dialogues
  - Weakening or reducing intensity
  - Including others (therapist, adult self)

Difficulties with Imagery

- Avoidance is the most common obstacle (in client and therapist)
  - Refuses
  - Being dismissive/disdainful of it's usefulness
  - Change the subject
  - Insist they cannot get an image
  - Wanting to use violence against abusers???
  - Fearful of violent reaction
  - Why does the therapist avoid…?

Imagery in offence focused work

- **Always complete re-parenting work on unmet childhood needs first – offence focused work is later stage**
- Offence disclosure
- Re-scripting offences
- Trauma focused work

- Enhancing victim empathy (noticing more in offence scenario – moving from a position of shame to guilt)
- Future scenario planning (behavioural pattern-breaking - desistance)
- Contraindications? – high sexual preoccupation (SSRI medication may assist therapy)

Desistance Theory (Moffitt, 1993)

- The process by where a person stops offending
  - Aging
  - Life Stability
  - Self Narrative – Redemption not Condemnation
  - Positive social identities…father….mentor….reformer
    - being realistic about the complexity and difficulty of the process
    - individualising support for change
    - building and sustaining hope
    - recognising and developing people's strengths
    - respecting and fostering agency (or self-determination)
    - working with and through relationships (both personal and professional)
    - developing social as well as human capital
    - recognising and celebrating progress

Dialogue/Chair Work

Core ways to use chairwork:

- External dialogues (Child – Parent)
- Internal dialogues (Child – Coping/Parent Modes)
- Corrective dialogues (Client – Therapist/ Client)
- Role-playing (Behavioural Pattern Breaking)

Role Play Practice

Challenges/Solutions in Chairwork

- Refusal
- Ridiculing
- Not staying in mode
- Play their modes for them
- Role switching
- Remain playful
- Keep momentum

Challenges of meeting needs in forensic clients and settings……?

- Navigating threats/aggression
- Care is aversive/rejected – ‘tough love’
- Care experienced as sexual/intimate
- Navigating ‘boundaries’
- Verbally attacking of staff/victims – triggering therapist
- Focus on the environmental realities
- Pathological litigation/complaints
- Perceptions of the ‘system’ towards limited re-parenting
- Self-disclosure and touch

Added value of ST in forensic settings

- Offending identity distanced from other parts – enables shame to be managed, increasing engagement
- Premise is that creating distance from offending as a functional response as increases ownership
- Parallels ideas of desistence, New Me, Good Lives Model (Tony Ward- www.goodlivesmodel.com)
- Chair work is useful in 'rolling with resistance' – drop the content – focus on process.

Schema Therapy
IS
Offence Focused Intervention

- Re-parent the Vulnerable Child Mode
- Set limits on the Angry Child Mode
- Banish the Punitive Parent
- Reduce the need for Coping Modes (offending behaviour – but can be AC too)
- Increase the autonomy of Good Parent/Healthy Adult

ISST

Forensic Schema Therapy: Best Practice?

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1. Schema Mode Work is the preferred form of ST practice

2. A high PCL-R score is not an exclusion criterion for treatment with ST.

3. It is advisable to educate professional staff in system about ST – its goals, principles, and methods

4. The successful implementation of ST depends on an institutional environment that is sufficiently safe and supportive of the patient's recovery.

5. ST ascribes to the forensic treatment principles of risk, need, and responsivity, namely that treatment should be provided for the patients who need it most, including those patients considered the most resistant to treatment, and should focus on ameliorating the underlying psychological risk factors for violence and recidivism in these patients.

6. As a general rule, psychiatric comorbidity (i.e., with Axis I disorders) is not a contraindication for SFT.

7. There are some comorbid conditions that MAY be contraindications for SFT, such as low intelligence, neurological impairment, autistic spectrum disorders, and certain psychotic disorders.....we have not found this to be the case.

8. The use of psychotropic medications is also not a contradiction for ST

9. ST must be combined with the established principles and practices of addiction treatment, if it is to be effective in the treatment of patients dually diagnosed with addictions and personality disorders.

10. Careful diagnosis and assessment of patients is an essential precondition for ST. Not seen as necessary in UK

11. The rigors of working with forensic patients make the need for thorough training of ST therapists imperative.

12. Regular supervision or peer supervision sessions are necessary to insure the effective delivery of ST in forensic settings.

13. Therapists should have at least 3 years of prior psychotherapy experience before they attempt to master ST (we often use schema informed practice)

14. Competency ratings for therapists should become standard practice, particularly in forensic settings in which the therapists' competency may affect patients' recidivism risk.

Did this workshop meet your needs?

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