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Introduction

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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.
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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.