Hello from Brisbane - Australia

- Queensland
- 2nd largest & 3rd most populous Australia state
- 5.1 Million people
- Famous for the Great Barrier Reef & the Daintree Rain forest
- First inhabited by Aboriginal Australians & Torres Strait Islanders (nowadays about 3.2% of total pop of Aus)
- Discovered by the Dutch in 1606, and then the British in 1770
- Rugby League is the number one sport!

BETTER THE DEVIL YOU KNOW

SCHEMA THERAPY WITH FORENSIC CLIENTS, ISSUES & CONTEXTS

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Advance Accredited Schema Therapist, Supervisor & Trainer

Clinical & Forensic Psychologist

Forensic Schema Therapy

- Relatively new innovation pioneered by David Bernstein and colleagues in the Netherlands in the mid to late 2000's
- Introduced the so-called forensic schema modes:
  - the **bully & attack;**
  - the **self-aggrandizer;**
  - the **predator;**
  - the **conning-manipulator;** and,
  - **The paranoid-suspicious/obsessive over-controller**
- Working with severe personality disorder and helping make sense of offences that often can appear inexplicable

Evidence base accumulating for Forensic Schema Therapy

RCT:

Bernstein DP et al (2021). Schema therapy for violent PD offenders: a randomized clinical trial. **Psychological Medicine** 1–15.

Bernstein, D. P., Nijman, H. L., Karos, K., Keulen-de Vos, M., de Vogel, V., & Lucker, T. P. (2012). Schema therapy for forensic patients with personality disorders: Design and preliminary findings of a multicenter randomized clinical trial in the Netherlands. I**nternational Journal of Forensic Mental Health**, 11(4), 3 12–324.

Published single case Studies:

Chakhssi, F., Kersten, T., de Ruiter, C., & Bernstein, D. P. (2014). **Treating the untreatable: A single case study of a psychopathic inpatient treated with schema therapy.** Psychotherapy (Chicago, Ill.), 51(3), 44 7–461.

To be published single-case Study:

Madsen, L. & Bernstein, D.P. (2022). Untangling sexual murder: A Forensic Schema Therapy Case Conceptualisation of a child murderer. Book Chapter to be published.

Forensic Contexts:
The Devil's in the Detail

Forensic Contexts

- Patients are typically **mandated** to attend treatment
- **Goals and Objectives** of the treatment will typically relate to criminogenic issues and concerns (ie., reducing risk of violence etc.)
- **Little control, coercive environments,** consequences for noncompliance, poor engagement, lack of progress
- Correctional contexts **can be dangerous, exploitative and not supportive of progress / 'healthy adult' behaviour**

Rehabilitation

- Mainly **group programs** offered with specific focus on violence, sexual offending, drug and alcohol addiction and problems
- Programs, typically, skills based **Cognitive behavioural** and/or Motivational Interviewing
- Some opportunities of improving education (trades & university)

Legislative Changes

- The emergence of the laws for ***post sentence detention and supervision*** specifically targeting sexual offenders emerged in early 2000's
- Qld DPSOA 2003 was first though followed by similar laws in Western Australia & NSW in 2006, Victoria 2009, and Northern Territory 2013 (McSherry, 2013)
- Similar to '**Sexual Predator Laws**' in the USA, which had been around since 1930's, however, it wasn't until the early 1990's that such schemes became increasingly prevalent throughout the USA

In forensic contexts
culture matters

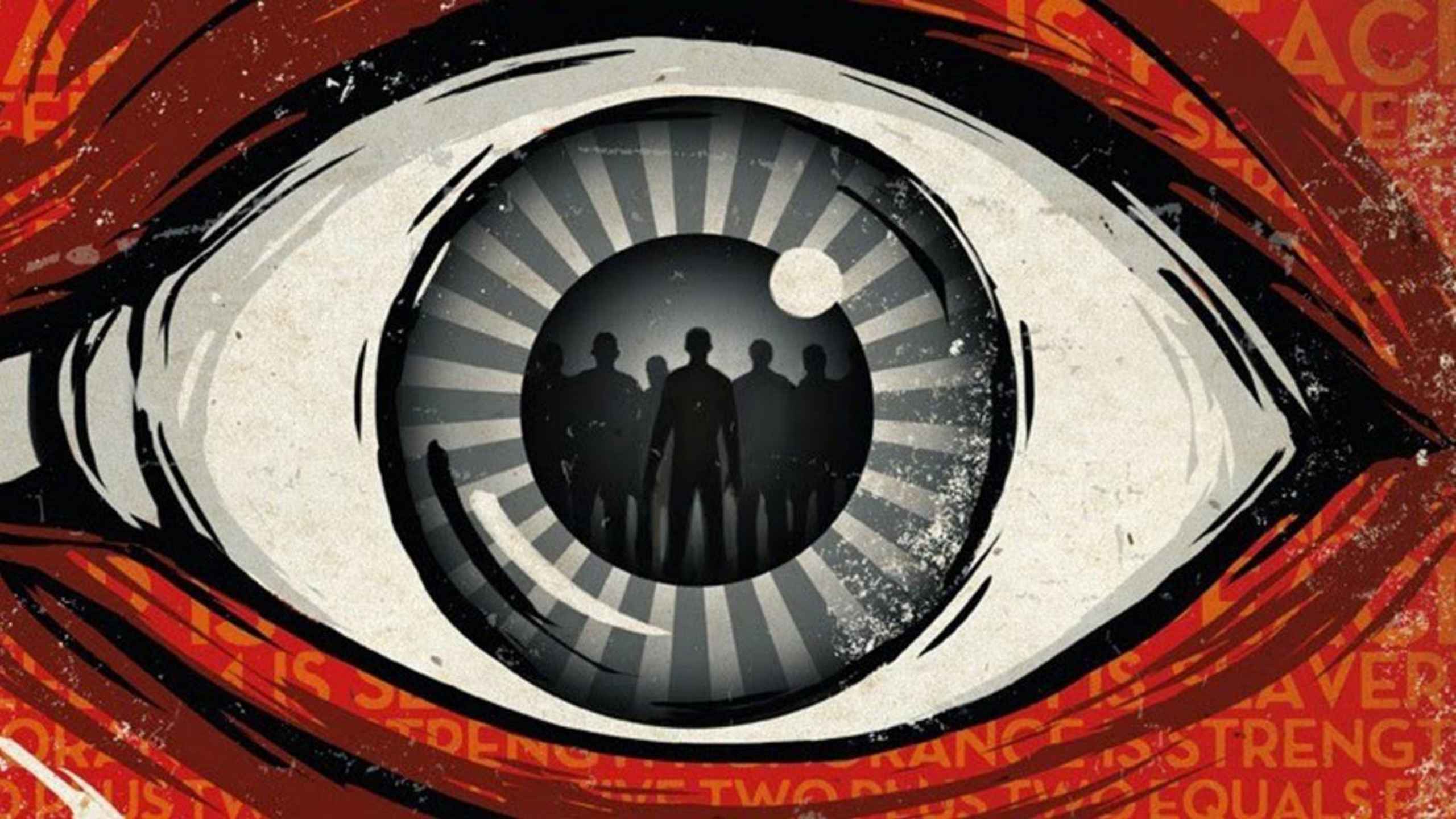
The pressures…

Workplace can be:

- **Clients extrinsically motivated – ticking a box**
- **'Institution' does not care about mental health outcomes only risk assessment**
- **Cynical and pessimistic about rehabilitation and progress**
- **View clients as untreatable**
- **Minimised, dismissive and intimate collusion of clinician with client**

Tensions within clinician

- Imposition of goals (**risk** vs **needs** vs **institutional demand**s)
- Trust vs. Doubt vs Mistrust
- Balancing respect vs collusion
- The need to confront and set limits
- Balancing relationships with institution (parole etc.)



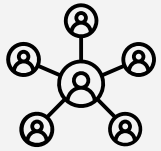
Balancing Culture Vs. Therapy Effectiveness within Forensic contexts (e.g. Hackett, 2000; Ahmad, 1992)

Ineffective
Permissive
'Offender focused'

Perpetrator seen as **victim** who continues to be **victimized**
Must be **rescued**

Act as an **advocate**,
No accountability
Risk minimised

Effective
Balanced focus, Empathic, Boundaried,



Collaborative: perpetrator, other relevant agencies

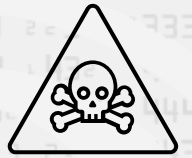
Perpetrator is seen as **capable of change**

Specific **Goals** & objectives

Risk focused
Accountable
Offending is understood
Through **shared Risk formulation**

Compassionate,
Interpersonally warm

Ineffective
Punitive
Judgmental



Perpetrator is seen as **unchangeable,**
Everything is about Offending all the time

Act as prosecutor, inquisitor, looking to catch him out
punish &
exclude

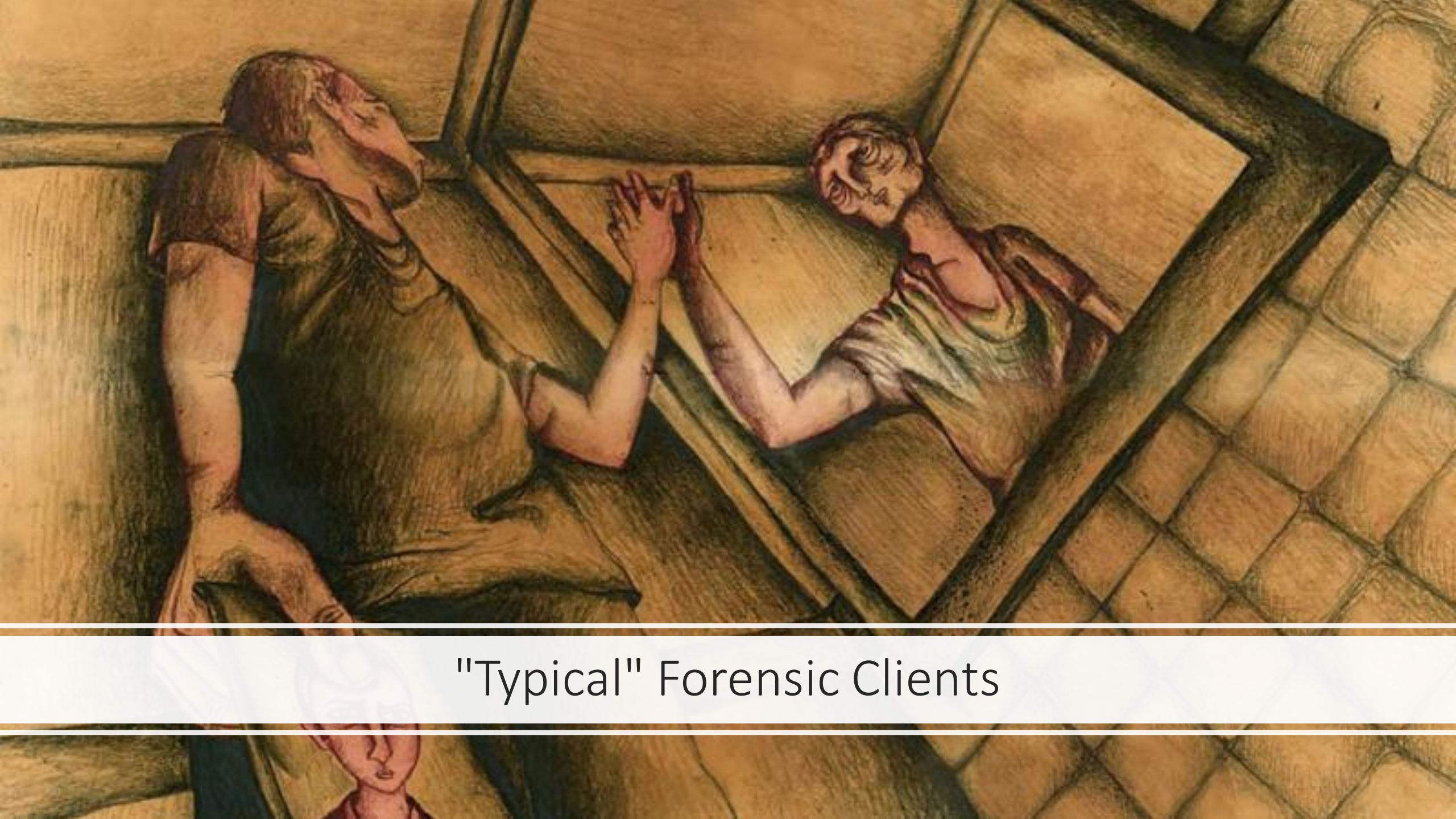
Underestimates risk

Overestimates Risk

Forensic + Clinical Psychology Centre
Treatment | Assessment | Consultancy

Context: What can you do about it?

- You need to **understand the context**:
  - What does the institution/client need? How does the system work? Who makes decisions?
- **Points of leverage** with client
  - What does the client want? Why would they intrinsically do ST? What can you negotiate with them knowing that motivation is dynamic
  - What promises can you keep? What can you not promise?
  - Goals **MUST BE MEANINGFULLY LINKED TO RISK**
  - Love is never enough – it's a business transaction (i.e., *you give a bit you get a bit*...)
- Communicate with **data** (if possible)
  - Always look for data (i.e., incidents, changes in specific behaviour, time between averse incidents
- Watch culture and **understand the impact** that it has on you?
  - Which end of the spectrum are you finding yourself pushed or pulled towards? Why?



"Typical" Forensic Clients

Typical childhoods

- **High stress family context**
  - Single mother / blended families / foster care
  - Parental psychological problems, mental illness, drug and alcohol problems
  - Parental criminality
  - Poverty
- **Exposure** to, and a victim of, physical, emotional and sexual abuse
- Early behaviour problems & mental health diagnoses (e.g. ADHD, Conduct Disorder, ODD)
- Poor educational attainment, learning disability, school exclusion due to behaviour problems

Typical Childhood themes

'It's a **dog-eat-dog world'** - vulnerability is weakness and weakness is exploited...

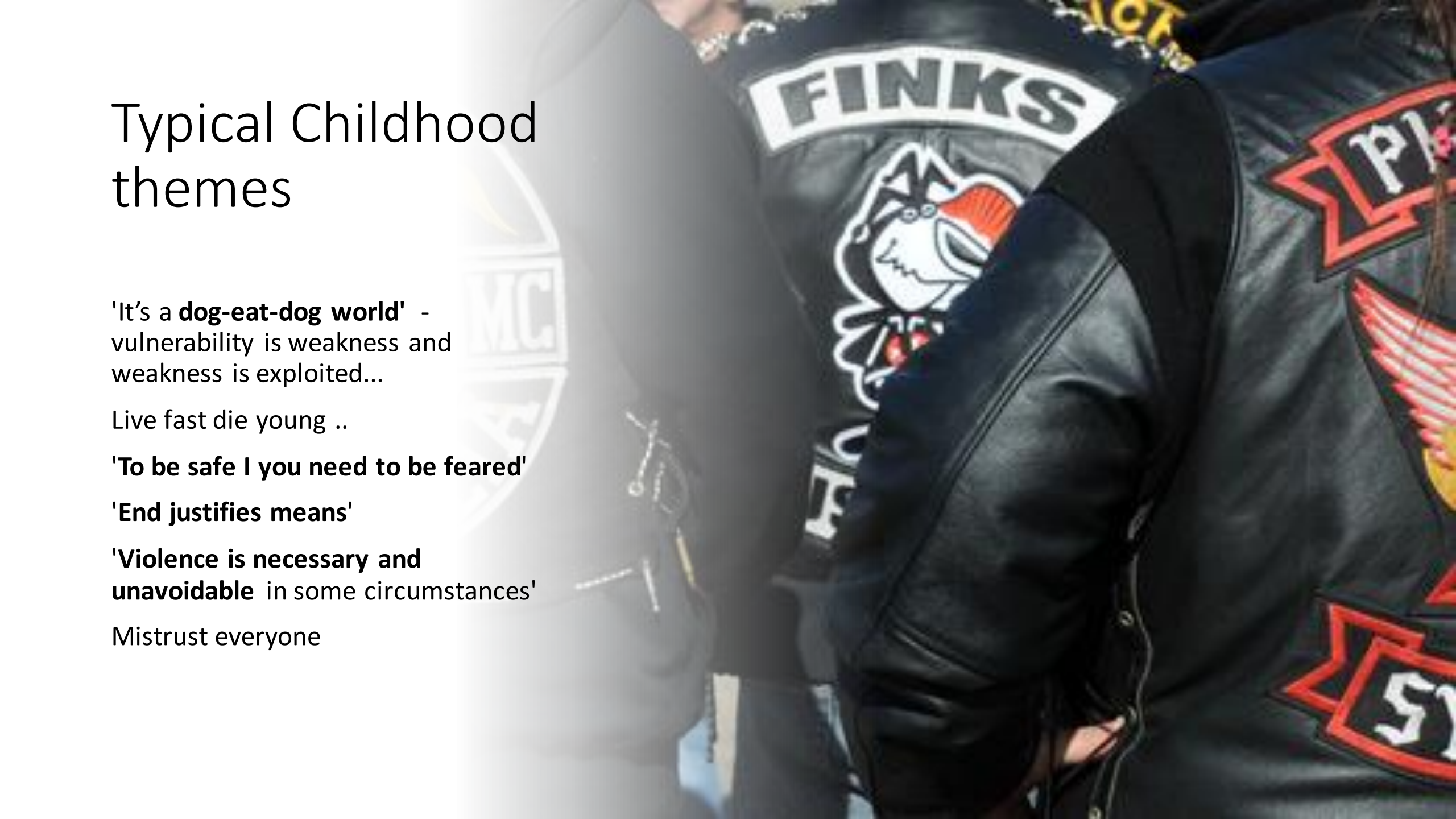
Live fast die young ..

'**To be safe I you need to be feared**'

'**End justifies means**'

'**Violence is necessary and unavoidable** in some circumstances'

Mistrust everyone



Childhood Maltreatment and Personality Disorders

(Lobbestael, Arntz, & Bernstein, 2010)

- Lobbestael et. Al., (2010) investigated the relationship between five forms of childhood maltreatment: sexual, physical and emotional abuse, emotional and physical neglect and 10 personality disorders (PDs)

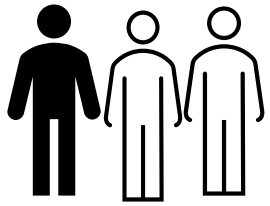
Results indicated that:

- **Sexual abuse** was associated with symptoms of p**aranoid, schizoid, borderline, and avoidant** PD
- **Physical abuse** with **antisocial** PD
- **Emotional abuse** with **paranoid, schizotypal, borderline**, and cluster C
- **Emotional neglect** with **histrionic and borderline** PD

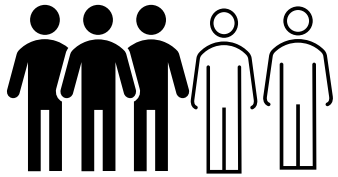
Compared to everyone else (e.g., Aklers, et. al., 2011; NOMS, 2015; Santilla, et. al., 2010)

	General Pop	Clinical Pop	Psychiatric Hos Pop.	Prisoners	QLD
Personality Disorder	5 – 10%	20 – 30%	30 – 40%	**60 –70%**	**96%**
Psychopathy	0.75 - 1%	-	-	**10 – 15%**	**28%**
Sexual Deviancy	3 – 9% (males)	-	-	-	**67%**

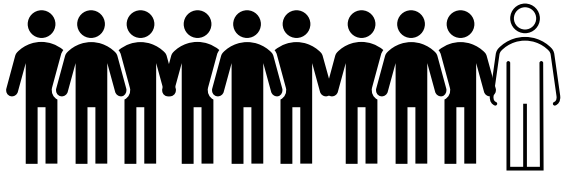
Descriptive Characteristics of QLD (n=54)



@1 in 3 **Psychopathic** (28%)



@ 3 in 5 **Sexually deviant** (67%)

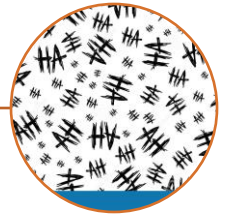


@ 9 out of 10 **Personality Disorder** (96%)

97% Personality Disorder

73% **Antisocial**

41% **Paranoid**



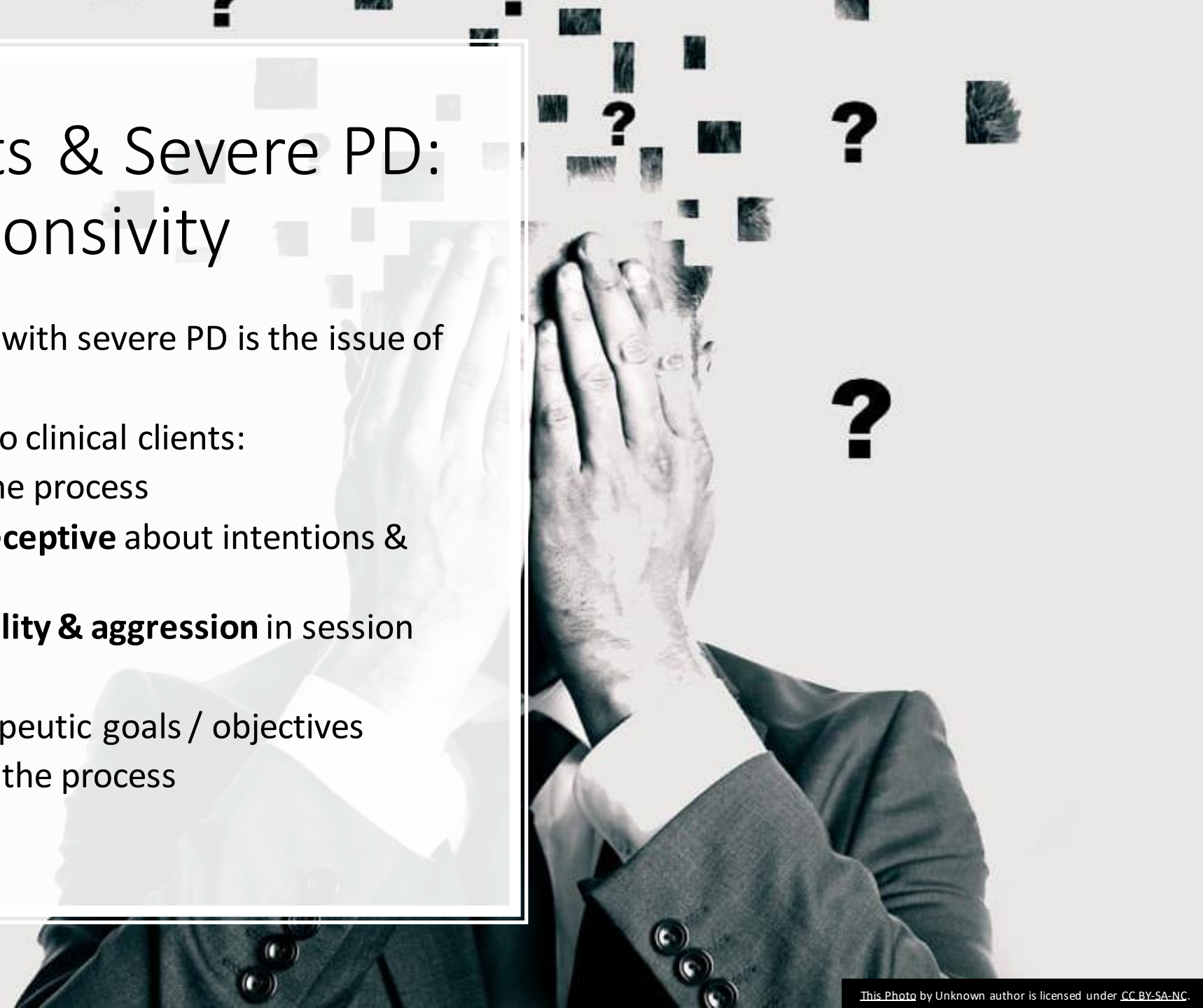
34% **Narcissistic**

Forensic rehabilitation: Risk-Needs- Responsivity Model (RNR) (i.e., Blanchette & Brown, 2006; Ward, et. Al., 2007)

- The **RNR model** is a widely used framework guiding treatment of offending populations. The model is based on extensive research into the factors which predict recidivism – these are the key dynamic (i.e., changeable) risk factors that are most strongly related to recidivism
- Proposes that **intervention with offenders works best** when:
  - **Risk**: Targets high-risk offenders
  - **Needs**: Targets the characteristics that are changeable and related to risk
  - **Responsivity**: Uses methods and techniques that are accessible to the patient (i.e., accounting for personality, intellectual functioning, mental health problems etc.)

Forensic Contexts & Severe PD: the issue of responsivity

- One of the biggest challenges with severe PD is the issue of **responsivity**
- Forensic clients are different to clinical clients:
  - **More Mistrust** you and the process
  - **More Exploitative and deceptive** about intentions & goals
  - **More Interpersonal hostility & aggression** in session
  - **More Impulsivity**
  - **More Resistance** to therapeutic goals / objectives
  - **More Attempt to control** the process
  - **More Detachment**



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The Forensic Modes

Forensic Schema Therapy (FST) (Bernstein, et. al., 2019)

- Places a much greater emphasis on the modes & conceptualises the 'responsivity' challenges often experienced as evidence of the patient's maladaptive coping modes, specifically the overcompensating modes

- These **maladaptive coping modes** typically have emerged in childhood in challenging circumstances, and served to help the patient feel safe, get their needs met, and generally survive in the world

The Bully & Attack Mode (Bernstein, et.al., 2007, 2019)

Key Signs

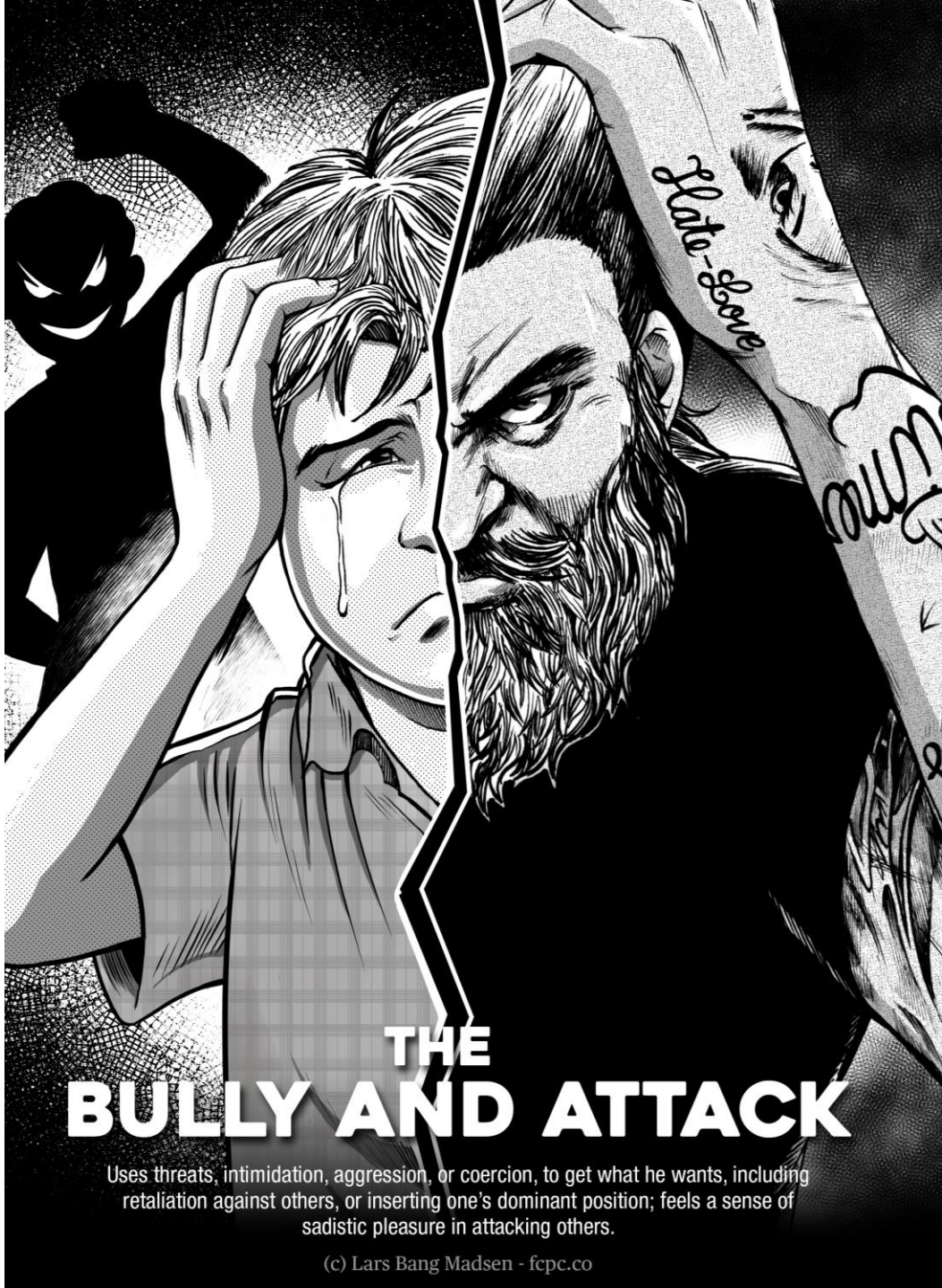
Presents in intimidating, threatening & aggressive manner –both verbally & non-verbally

Objective of behaviours is to *put someone in their place*, to *make them feel unsafe or scared*

Different type of anger to angry child or angry protector - *targeted*

Function: Sometimes to overcompensate for feelings vulnerability, powerlessness, etc

Typical feelings: Scared, threatened, unsafe



The Self Aggrandizer Mode (Bernstein, et.al., 2007, 2019)

Key Signs:

Likes to present self in a good light – tells stories about his specialness, superiority, normal rules don't apply to me

Experienced by others as arrogant, likes to talk about self

Puts others down, including the therapist, dismissive

Function: Sometimes to compensate for feeling defectiveness, shame, worthlessness

Typical feelings: Annoyed, put-down / belittled, anxious to impress

The conning manipulator mode (Bernstein, et.al., 2007, 2019)

Key Signs:

Uses indirect methods to get what he wants. May present as a perfect patient, flatter the therapist and the therapy. May make up stories to garner sympathy including using their own trauma in an instrumental manner

May try to get favours, be owed something or encourage the therapist to violate boundaries in one way or another to have something over them

Lies

Typical Feelings: Confused, things don't add up, manipulated

Suspicious & Paranoid Over-controller (Bernstein, et.al., 2007, 2019)

Key signs

Uses vigilance to protect, scanning other people for signs of malevolence

Hypervigilance

Attempts to protect oneself from a perceived or real threat by focusing attention, ruminating, and exercising extreme control in the environment

Always on the look out or trying to locate and uncover a hidden (perceived) threat

Hostile attribution bias

Typical feelings: Difficult to connect with, over explaining, justifying, trying to prove yourself/rationalize

The Predator (Bernstein, et.al., 2007, 2019)

Key signs

In this mode the patient is cold and detached and determined (THINK Jason from Friday 13th or Michael Myers in Halloween). Violence is cold and calculating. Different than bully & attack where the motivation to intimidate and threaten, the predator is orientated to achieving a goal or objective.

Instrumental violence

Debt collect / hit man 'just business'

Purposeful and controlled

Typical feelings: Scared, things aren't right, unsafe, the other person is unreachable

Sources of Forensic Modes

A **modeled strategy** that has practical utility in a dangerous environment

"*My earliest memory was seeing my mother be raped by my dad... I was then also abused... when I went to the boy's homes, the older kids would get me, that happened, until I was the oldest and non-one could get me. I started raping the younger ones and it felt good to have control and power. In prison, rape became a stragey for control and power, not just pleasure although I enjoyed raping guys. I also knew that it scared the shit out of anyone who challenged me... You come for me, and I will get you eventually no matter what. I controlled everything.*" - Ray.

Prominent Modes: **Predator / Bully & Attack / Self Aggrandizer Modes**

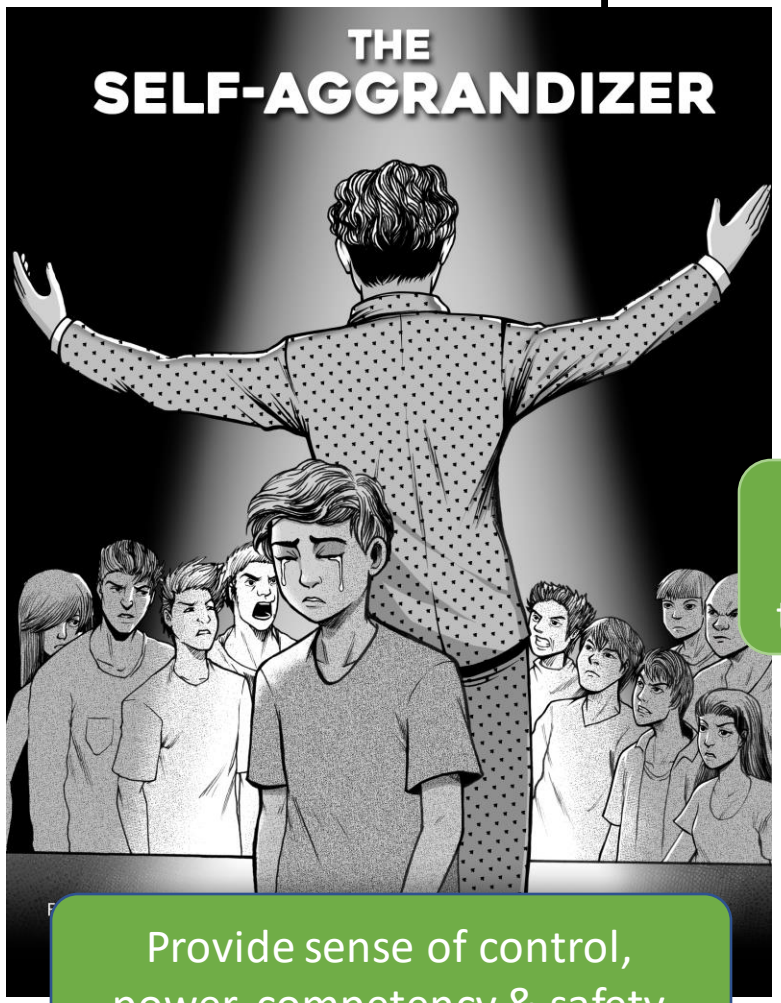
Sources of Forensic modes

- A **learned strategy** that

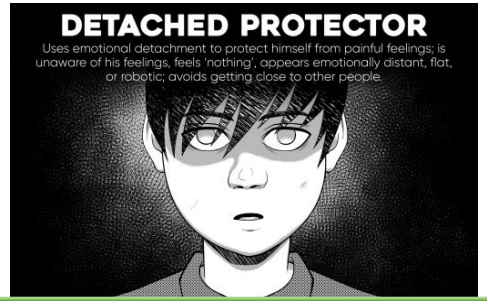
- *"I am smarter than most of the guys in here. I know I can manipulate them easily and get them to give me things or do things for me without violence. I just pick a vulnerable one and tell them that a gang or someone dangerous is going to get them, but I can help them. I can protect them …. it'll cost you though, and I name my price… money, drugs, clothes, sex, anything really… it's easy*" - Steve

- Prominent mode: **Conning Manipulator**

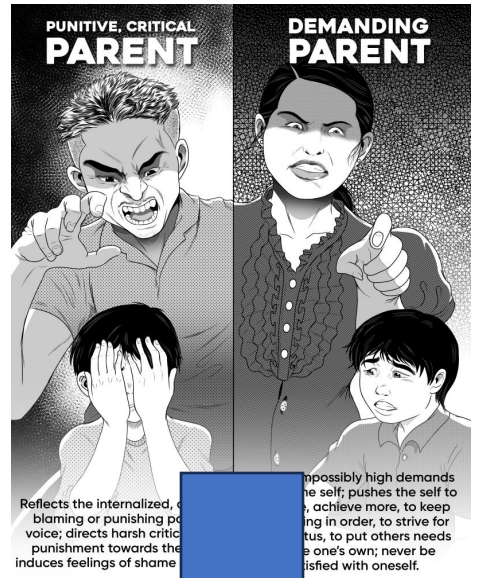
Mode Maps: Narcissistic Clients (Young, et. Al. 2003)

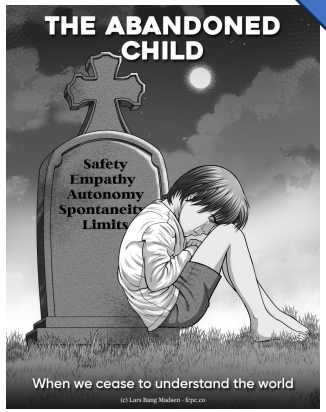


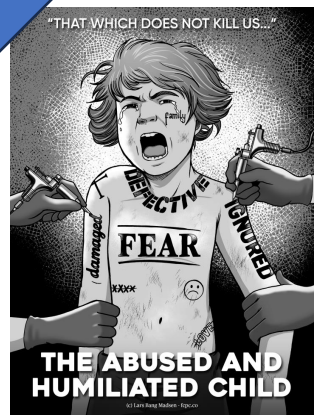
Provide sense of control, power, competency & safety



Avoidant modes provides escape & soothing alternative to emptiness / emotional pain



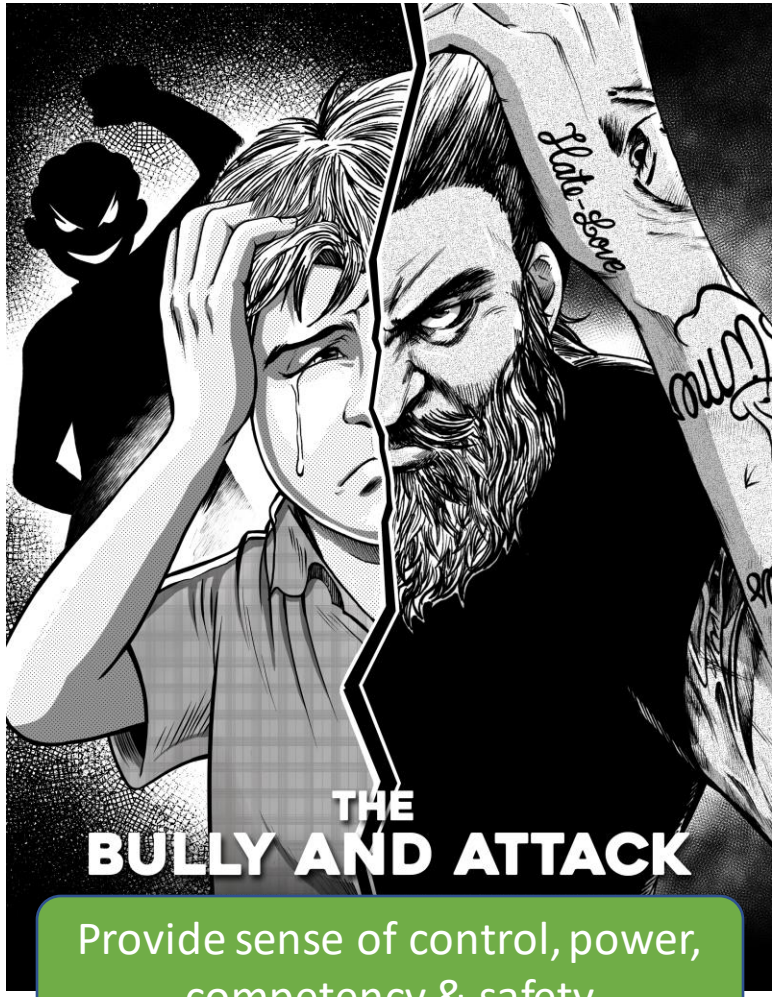




Relationship to offending (e.g. NOMS, 2015)

- Narcissistic PD alone is not frequently associated with serious offending.
- There may be transgressions when the individual will not adhere to social rules; alternatively if the illusion of specialness is exposed, and vulnerability unprotected, shame may result in eruptions of rage.
- When narcissism combines with antisocial traits, the likelihood of offending is higher.
- Narcissistic traits are evident in some offenders who lash out in response to perceived slights, and in a subgroup of high risk paedophile offenders who believe themselves to be attractive to pubescent boys.

Mode Maps: Antisocial Clients (Bernstein, et.al., 2007, 2019)



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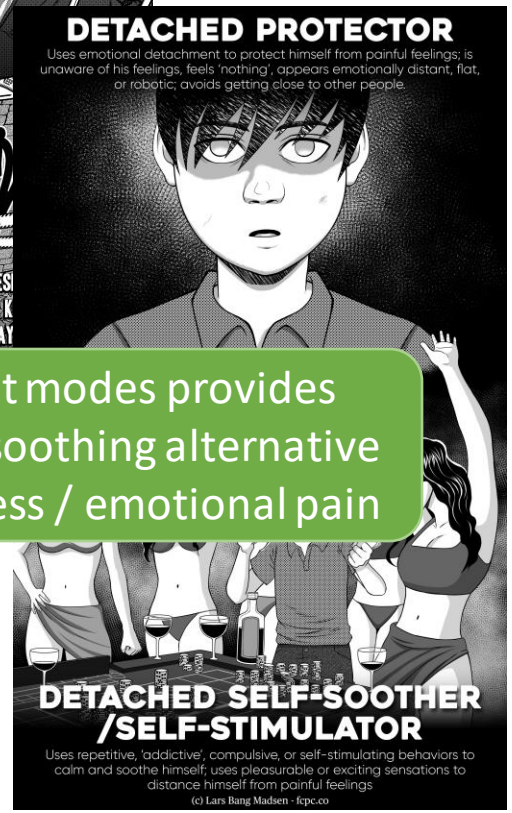

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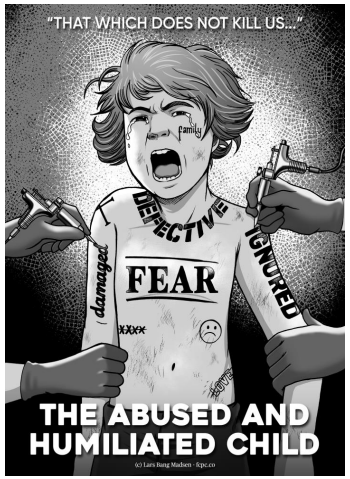


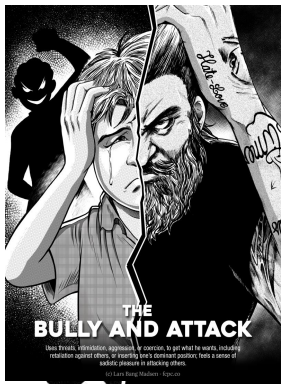
Relationship to Offending (i.e. NOMS, 2015)

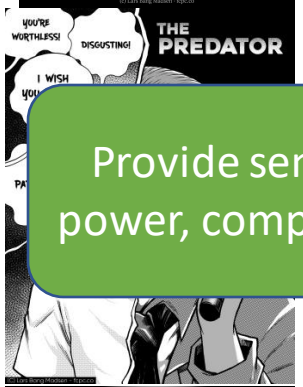
- **Most prisoners may meet the criteria for ASPD.**
- Associated with an increased likelihood of **general recidivism, violence and, to a lesser extent, sexual offending.**
- Among sexual offenders it is **far more common among rapists than child sexual offenders.**

ASPD may be linked to offending in a number of ways:

- They may have a tendency towards acting out aggressively when faced with inner conflict (such as feelings of frustration, anxiety or helplessness).
- They may experience others as threatening and therefore possess a strong need for dominance.
- They may be highly impulsive, this is likely to get them in to trouble.
- Substance misuse is common and when combined with antisocial traits, risk of harm (self and others) increases considerably.

Mode Map Psychopathy Clients





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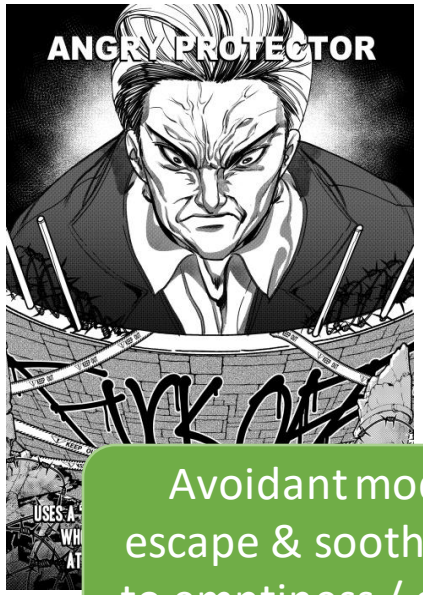

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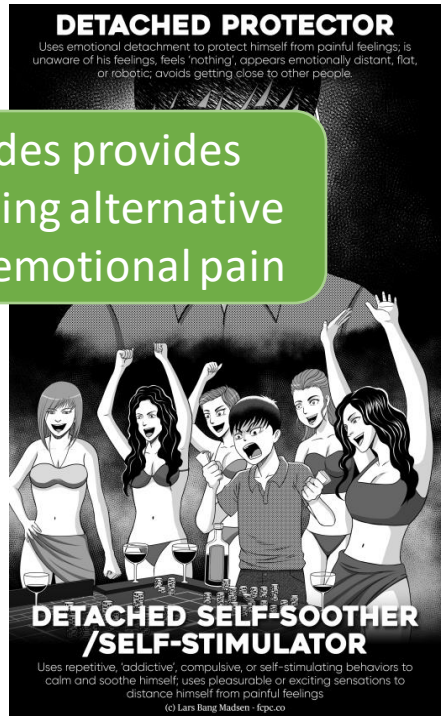
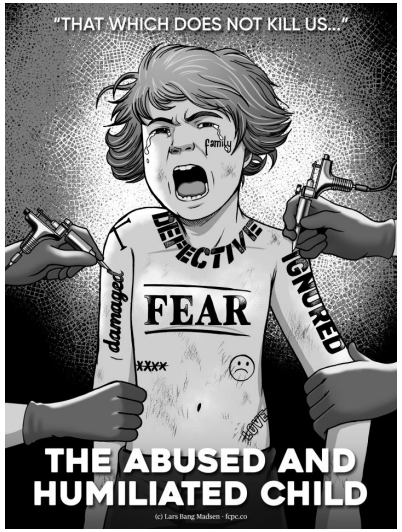
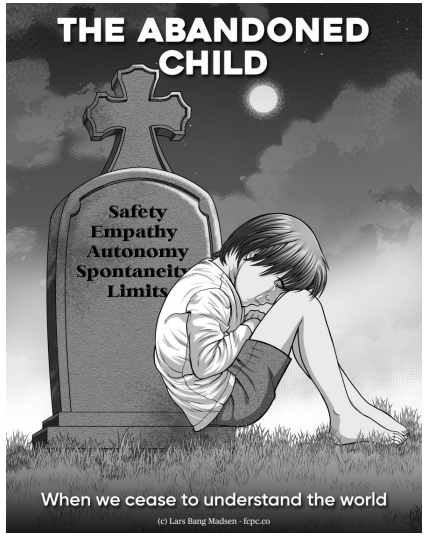
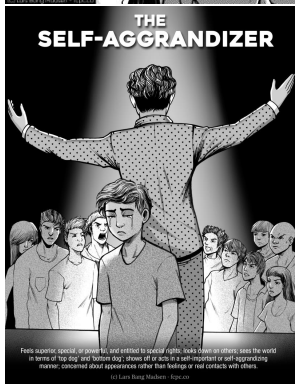








Relationship to Offending(e.g. NOMS, 2015)

- Psychopathy is associated with an **increased likelihood of general and violent recidivism**, along with **problematic institutional behaviour** and **difficulties engaging in and benefiting** from interventions to address risk.

Psychopathic individuals may offend in a number of ways:

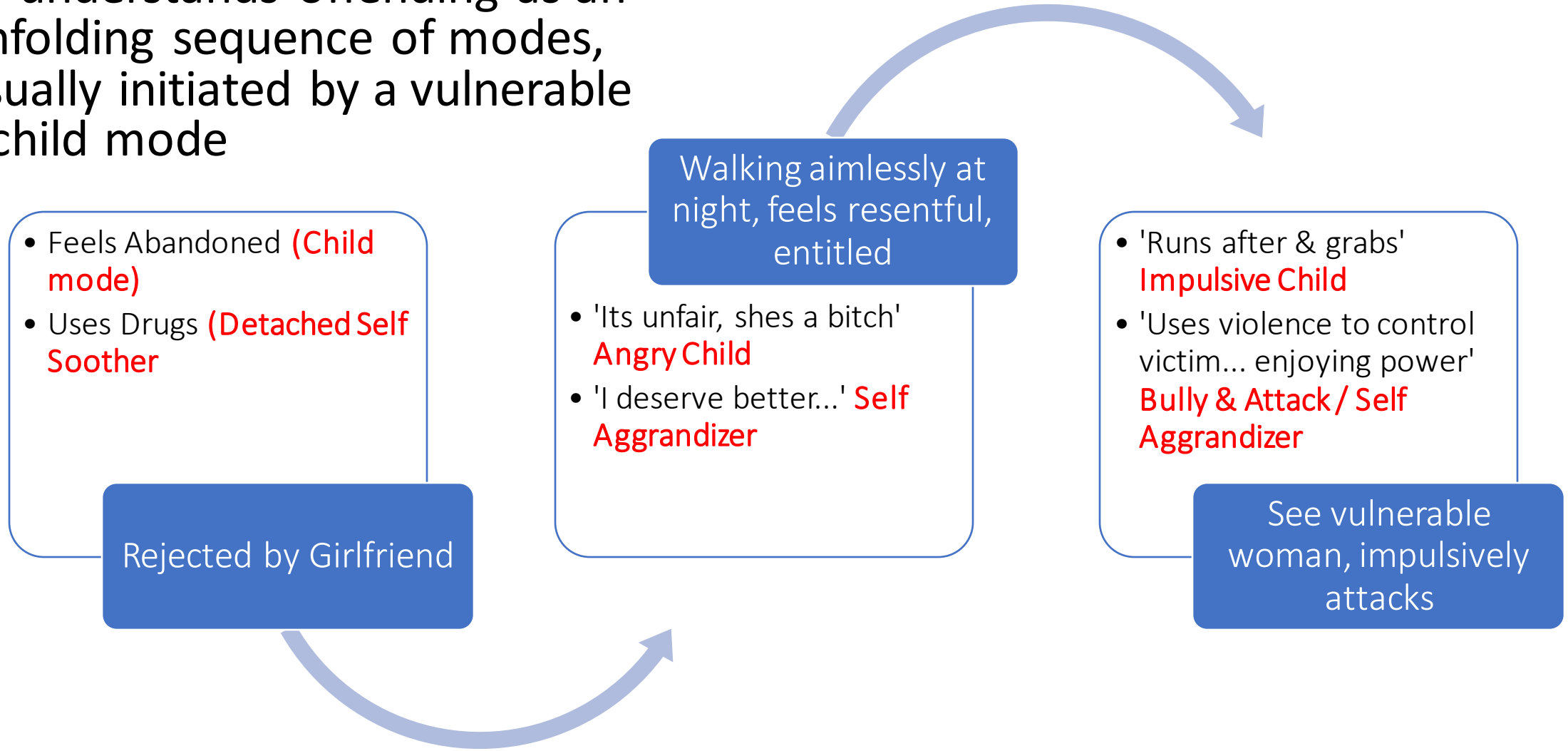
- They may be **highly impulsive**, which is likely to get them into trouble.
- They generally **do not care about rules** and so sanctions will have little impact in guiding self-regulation.
- While they can be **hot headed** they may also be likely to use **instrumental violence** to achieve their aims.
- They have li**ttle or no concern for the impact of their behaviour on others** and so do not try and avoid harming others when pursuing their own interests.

Goals of Schema Therapy with Forensic Clients (Bernstein et al., 2007, 2019)

- Reduce **risk of reoffending *** (PRIORITY)**
  - Offending is conceptualised in terms of **MODES and MODE SEQUENCES**
  - Risk is understood in terms of **PRESENCE or ACTIVATION of Offence-Related Modes**
  - Offending Modes are never considered to be eliminated, **they are only managed and contained**
  - **Similarly, RISK is never considered zero**
- **Improve HEALTHY ADULT** functioning and presence
  - Assist client get his core emotional needs met in ways that do not put himself or others at risk of harm
  - Healthy Adult acts as protective factor

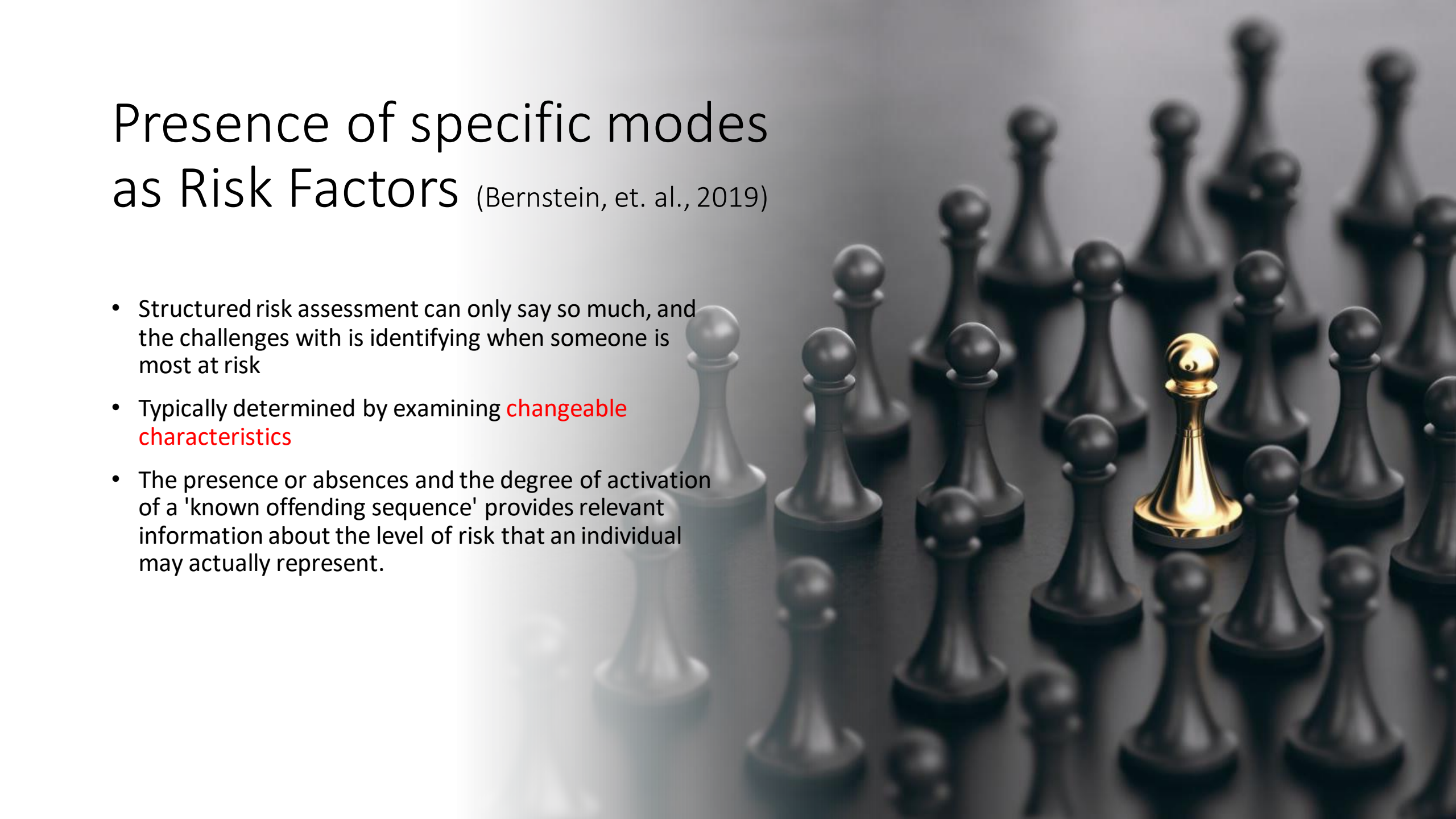
Making Sense of Offending (Keulen-De-Vox et al., 2014; Jones, 2004; Daffern et al., 2007)

- ST understands offending as an unfolding sequence of modes, usually initiated by a vulnerable / child mode



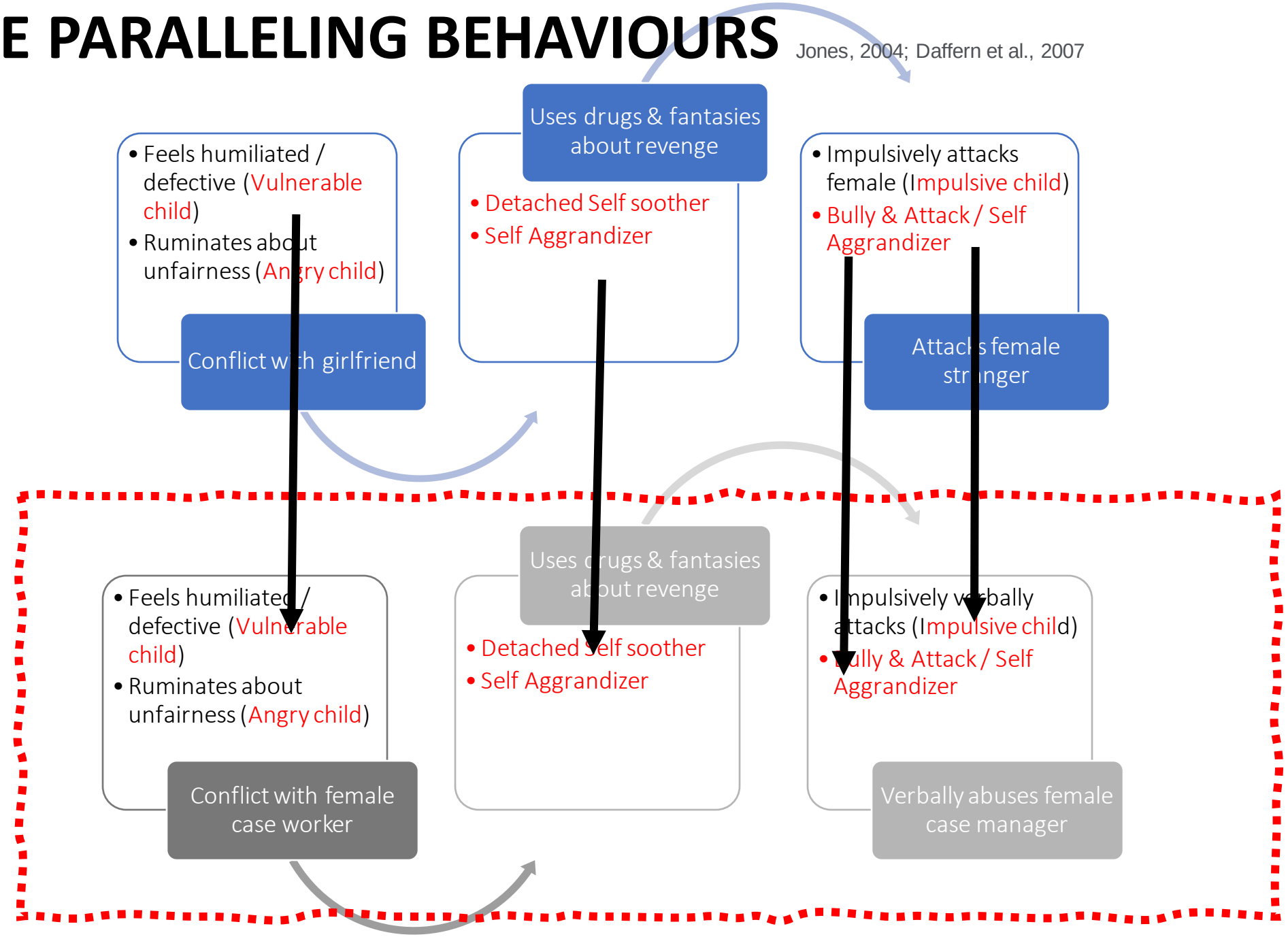
Presence of specific modes as Risk Factors (Bernstein, et. al., 2019)

- Structured risk assessment can only say so much, and the challenges with is identifying when someone is most at risk
- Typically determined by examining changeable characteristics
- The presence or absences and the degree of activation of a 'known offending sequence' provides relevant information about the level of risk that an individual may actually represent.



OFFENCE PARALLELING BEHAVIOURS

Jones, 2004; Daffern et al., 2007



Working with Modes

- Greater emphasis on the ***here and now,*** what is happening in the room

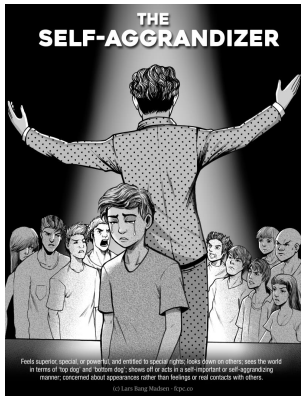
- Key is being able to **identify the right mode and then pick the right type of intervention**

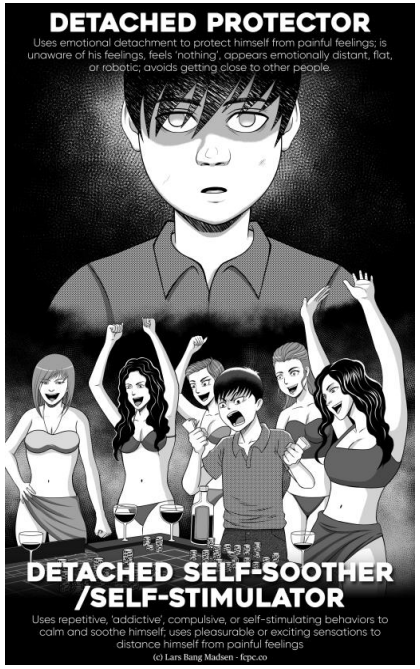
- **Misjudging** the modes and using the **wrong intervention** can lead to problems (Bernstein & Navot, 2022)

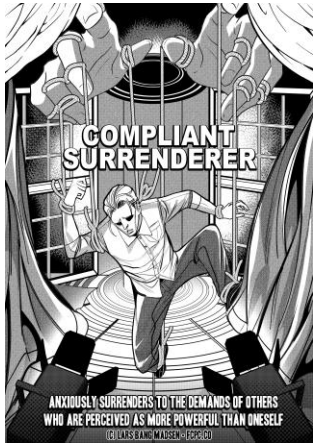
Overcompensating / Avoidant / Surrenderer Modes: The 'right' intervention (Bernstein & Navot, 2022)

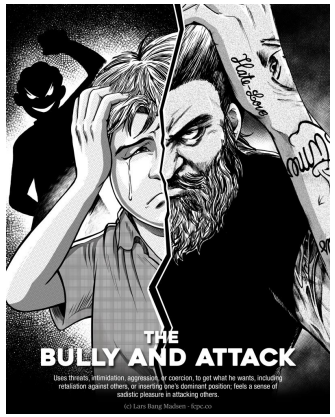
Limit Setting & Empathic Confrontation

Not Limited Reparenting



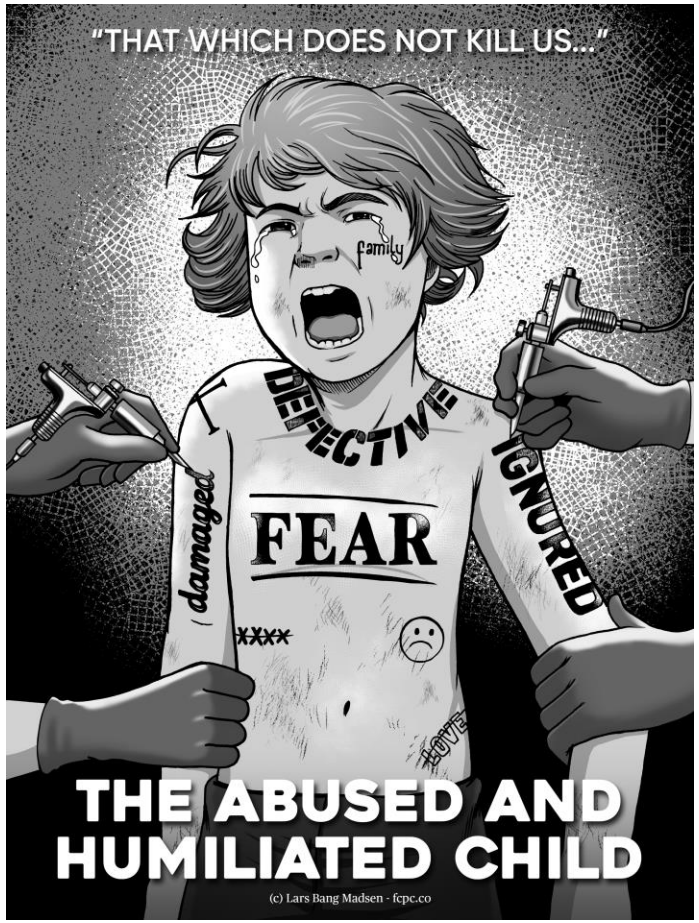






Vulnerable Child Modes: The right intervention(Bernstein & Navot, 2022)

Limited Reparenting



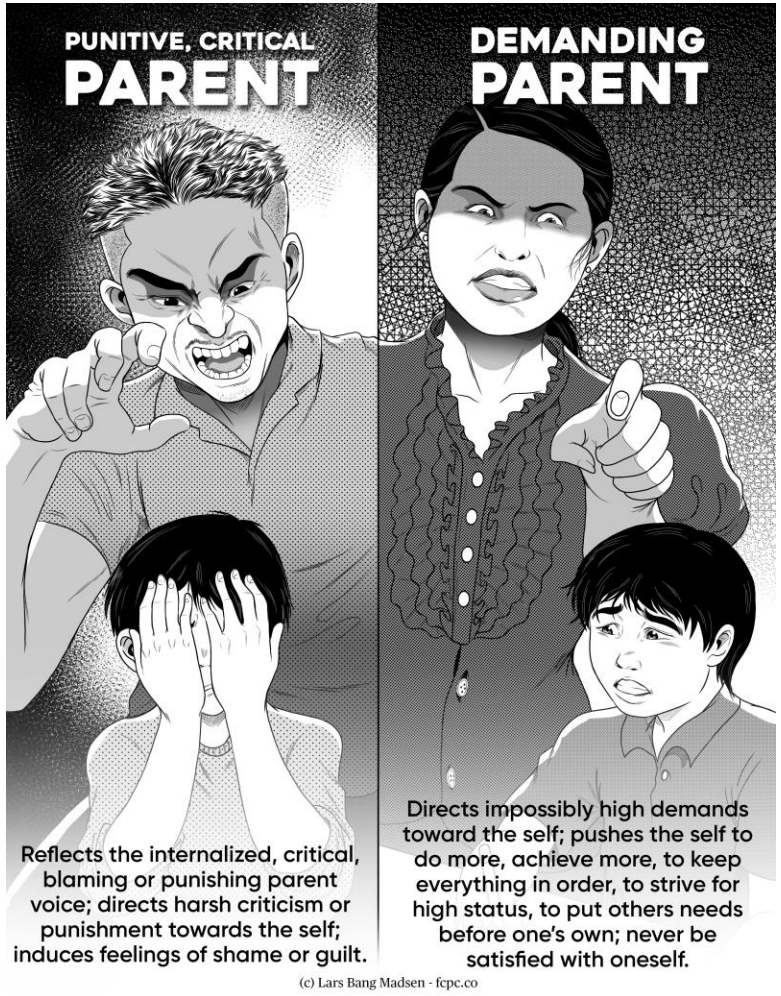
Impulsive & Undisciplined Modes: The right intervention (Bernstein & Navot, 2022)

Empathic Confrontation and/or Limit Setting

Parent Modes (Bernstein & Navot, 2022)

Talk Back

Limit Setting



Ensure that the intervention matches the mode

Modes	Intervention
Vulnerable modes (Abandoned, Abused, Humiliated, or Lonely Child)	Limited reparenting
Angry Child	1. Listen, 2. show empathy, and 3. switch from Angry Child to Healthy Adult or Vulnerable Child mode.
Impulsive Child or Undiscplined Child	Empathic confrontation, or limit setting
Critical or Demanding Parent	Talk back to the mode
Avoidant, Surrender, or Overcompensatory	Empathic confrontation, or limit setting

Creative Methods in Schema Therapy: Advances and Innovation in Clinical Practice, Chapter 12 Bridging the gap between forensic and general clinical practice. David Bernstein and Limor Navot pg 203-204.

5 Take Aways for Schema Therapy in Forensic Contexts

1. **Know Your Context:** Who makes decisions? What is the process for progression?
2. **Love is not enough** – It's a negotiation. What's your leverage? What promises can you keep?
3. Therapy is about **RISK REDUCTION** (reducing the related modes & increasing the healthy adult)
4. **MODES MATTER** in the session, in offending and in risk assessment
5. The **RIGHT intervention for the RIGHT mode!**!

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