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Article · May 2019

DOI: 10.1002/9781119139980.ch41

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Publisher : John Wiley & Sons, Ltd
Location : Chichester, UK
ISBN (print-13) : 9781119139683
Title (main) : The Wiley International Handbook of Correctional Psychology

Numbering (edition) : 1

Creators (editor) : Devon L. L. Polaschek

Creators (editor) : Andrew Day

Creators (editor) : Clive R. Hollin

Subject Info : http://psi.wiley.com/subject/

Title (main) : Treatment
Title (subtitle) : Modalities and Approaches
Title (name) : Part
Numbering (main) : VII
ID (unit) : c41
ID (file) : c41
Event (xmlCreated) : 2018-11-12 (SPi Global)
Numbering (main) : 41
Numbering (pageFirst) : 654
Numbering (pageLast) : 668
Attribute Value (term) : abbreviation

41

Schema Therapy in Forensic Settings

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Schema therapy (ST) is an integrative therapy for individuals with personality disorders (PD) that combines cognitive, behavioral, psychodynamic object relations, and humanistic/experiential approaches. It is one of the few evidence-based treatments for borderline PD (Farrell, Shaw, & Webber, 2009; Giesen-Bloo et al., 2006; Nadort et al., 2009) and for Cluster C PDs (Bamelis, Evers, Spinhoven, & Arntz, 2014; Gude, Monsen, & Hoffart, 2001). Given the scarcity of evidence-based treatments for forensic patients with PDs, Bernstein and colleagues (Bernstein, Arntz, & Vos, 2007) adapted ST for forensic populations, especially those with antisocial, narcissistic, borderline, or paranoid PDs, which are the PDs most associated with recidivism risk in forensic settings. The forensic adaptation of ST focuses on modifying the repetitive, self-

defeating patterns (*early maladaptive schemas*) and emotional states (*schema modes*) that are prevalent in this population—such as states involving anger, impulsivity, aggression, superiority, deceit, and manipulation—and fostering healthy states involving self-reflection, self-regulation, and forming emotional connections with other people. This model also extends to treating psychopathic patients, who have traditionally been considered difficult, if not impossible, to treat (D'Silva, Duggan, & McCarthy, 2004). In 2007, Bernstein and colleagues initiated a 3-year, multicenter randomized controlled trial (RCT) to test the effectiveness of ST compared to treatment-as-usual (TAU) for forensic patients with PDs in seven hospitals (TBS [Ter Beschikking Stellig, treatment on behalf of the state] clinics) in the Netherlands (Bernstein et al., 2012). The study, which was recently completed, provides strong support for the effectiveness of ST with forensic PD patients (see Empirical Support, below). On the basis of these findings, *Erkenningscommissie* ("Recognition Commission") of the Netherlands has officially recognized ST as the first evidence-based treatment for forensic patients with PD (Erkenningscomissie Gedragsinterventies Justitie, 2015). In this chapter we describe the theory and practice of ST in forensic settings, drawing primarily on work conducted with forensic mental health patients. However, the approach also appears to hold promise as a treatment for more general correctional populations, including prisoners and those who are required to attend programs to address their offending behavior.

Clinical studies and meta-analyses indicate that PDs are highly prevalent in correctional settings. PDs are about three times more prevalent among male offenders than in the general population (Rotter, Way, Steinbacher, Sawyer, & Smith, 2002), and prevalence may be as high as 65% of all prisoners (Fazel & Danesh, 2002). In females, the prevalence is slightly lower, with 43% of a female correctional population meeting criteria for at least one PD (Tye & Mullen, 2006), but still much higher than in the general population. PD diagnoses are highly relevant to criminal behavior. Offenders with a PD diagnosis commit more violent and serious crimes (Blackburn, Logan, Donelly, & Renwick, 2003), and show higher recidivism rates, compared to non-PD offenders (Hart, Webster, & Menzies, 1993).

Although treatment is increasingly used to address aggression and recidivism in offender populations, most are based on cognitive behavioral therapy (CBT) and only have modest effects (Ross, Quayle, Newman, & Tansey, 2013; Wong, Gordon, Gu, Lewis, & Olver, 2012). CBT tends to focus on controlling aggressive behavior (Timmerman & Emmelkamp, 2005), but usually does not address symptoms and characteristics associated with PDs. Moreover, offenders with severe PDs, especially criminal psychopaths, are usually considered difficult, if not impossible, to treat (Harris, Rice, & Cormier, 1991), despite the lack of methodologically sound RCTs to test this hypothesis (D'Silva et al., 2004).

Schema Therapy Theory

The theoretical base of ST stems from cognitive, behavioral, psychodynamic, and experiential traditions (Young, Klosko, & Weishaar, 2003). Originally, ST consisted of two concepts: early maladaptive schemas and coping responses. Early maladaptive schemas refer to dysfunctional themes or patterns concerning the self and one's relationships with others, which originate from adverse childhood experiences and the child's own innate temperament. Early maladaptive schemas are linked to unfulfilled or frustrated basic emotional needs that are present in all children: the need for attachment, autonomy, expression of emotions, spontaneity and play, and limit setting. What is important to notice for the purposes of both assessment and treatment is that early maladaptive schemas keep recurring over the course of the person's life: they are self-defeating and self-perpetuating. Maladaptive coping responses reflect three ways in which people behave when early maladaptive schemas are activated. First, they can give in to the schema (surrender); second, they can avoid situations that activate schemas (avoidance); and third, they can do the opposite of the schema (overcompensation; Young et al., 2003).

The concept of schema modes was introduced later because the standard model emphasizing schemas and coping response was of limited effectiveness in treating patients who presented with severe PDs such as borderline, narcissistic, and antisocial PD. Schema modes represent fluctuating states that dominate a person's emotions, cognitions, and behavior. The schema mode is determined by the early maladaptive schema that is activated, the emotional response that is elicited, and the coping response in reaction to

the emotion. Typically, four schema mode domains can be distinguished: (a) child modes, which refer to emotional responses that are nearly universal in children, such as fear, sadness, shame, anger, and impulsivity; (b) dysfunctional parent modes, which refer to internalized harsh parental demands or punitive criticism; (c) maladaptive coping modes, which refer to extreme attempts to cope with the activation of schemas, either through surrender, avoidance, or overcompensation; and (d) healthy modes, which reflect healthy self-reflection and feelings of joy and pleasure. Young et al. (2003) hypothesized that patients with certain PDs are characterized by specific patterns of schema modes. Borderline PD, for example, typically consists of five modes: the *Abused and Abandoned* child mode, which encompasses feelings such as fear, helpless, and desperate longing, which are often seen in individuals who experienced abuse or abandonment; the *Impulsive Child* mode in which someone acts on desires and impulses in an uncontrolled manner and with little regard to possible consequences; the *Angry Child* mode, which involves excessive and misplaced anger; the *Punitive Parent* mode, which involves harsh self-criticism and rejection; and the *Detached Protector* mode, which involves feelings of emotional numbness and detachment.

Forensic Theory

Certain emotional states, such as those involving deceit, ruthlessness, and aggression, are very prevalent in offenders but seldom seen in general psychiatric patients. Bernstein and colleagues (Bernstein et al., 2007; Keulen-De Vos, Bernstein, & Arntz, 2014) therefore extended the schema mode model to encompass the emotional states that are often seen in forensic patients. In particular, they observed that these patients often used five modes which involve overcompensation as a coping response. The *Self-Aggrandizer* mode involves dominance, arrogance, and superiority. The *Conning and Manipulative* mode involves deceiving, lying, and manipulation. The *Paranoid Overcontroller* mode involves hypervigilance for threats. The *Bully and Attack* mode involves the use of threats, intimidation, or aggression. The *Predator* mode involves cold, instrumental aggression to eliminate a real or perceived obstacle, threat, or rival. Recent research supports the idea that different patterns of modes are associated with different PDs (Bamelis, Renner, Heidkamp, & Arntz, 2011), that modes are triggered by external stimuli and have both cognitive and physiological correlates (Lobbestael & Arntz, 2010), and that they play a role in criminal and violent behavior (see Empirical Support). Table 41.1 provides an overview of all schema modes and their corresponding domains.

Table 41.1 Schema Modes and Corresponding Domains

Child modes	
Vulnerable Child (*Humiliated, Abandoned, and Abused Child*)	Feels vulnerable and overwhelmed by painful feelings of fear, depression, sadness, or shame/humiliation.
Impulsive/ Undisciplined Child	Acts like a spoiled child who "gets what she or he wants, when she or he wants it," and cannot accept the frustration of boundaries.
Angry Child	Feels and expresses uncontrollable anger in reaction to real or perceived abuse, abandonment, humiliation, or frustration; often feels treated unjustly; reacts like a child having a temper tantrum.
Lonely Child	Feels alone and empty because no one understands him, comforts him, or reaches out to him.
Avoidant and surrendering coping modes	
Detached Protector	Uses emotional detachment to protect himself against painful feelings; is unaware of his feelings and feels "nothing," seems emotionally distant, subdued or robot-like; avoids closeness to others.

Detached Self-Soother/ Detached Self-Stimulator	Repeatedly uses "addictive" or compulsive behaviors or self-stimulating behavior to calm or soothe the self; uses pleasant or exiting sensations to distance himself from painful feelings.
Complaining Protector	Complains, whines, and places demands in an unsatisfied victim-like manner; expresses dissatisfaction unsympathetically in a manner that hides his real feelings and needs.
Angry Protector	Uses a "wall of anger" to protect himself against others, who are experienced as a threat; keeps others at a safe distance by expressing large amounts of anger; anger is more controlled compared to the Angry Child mode.
Compliant Surrenderer	Readily gives in to real or suspected needs and demands of others who are experienced as more powerful in a fearful attempt to avoid pain and sadness.
Parent modes	
Punitive Parent	Internalized punishing, critical, or harsh parental voices; points strong criticism toward himself; creates feelings of guilt or shame.
Demanding Parent	Sets impossibly high standards and is never satisfied; pushes himself to do and accomplish more and more.
Overcompensatory coping modes	
Self-Aggrandizer	Feels superior, special, or powerful; looks down on others; sees the world in terms of winners and losers and constantly tries to show off. This expresses itself in magnifying behaviors which confirm his own importance; is more concerned with appearances than with feelings or real connections with others.
Conning and Manipulative	Cheats, lies, or manipulates to achieve a specific goal, which can either entail victimizing others or avoiding punishment.
Overcontroller (Obsessive-Compulsive or Paranoid)	Tries to protect himself against real or perceived threat by obsessively checking attention, behaviors, and thoughts. The Obsessive-Compulsive subtype uses order, repetition, or rituals. The Paranoid subtype tries to discover (perceived) hidden threats.
Bully and Attack	Uses threat, intimidation, aggression, and force to get what he wants, which includes revenge on others, and maintenance of dominance; experiences sadistic pleasure from attacking others.
Predator	Eliminates threat, rivals, obstacles, or enemies in a cold, ruthless, and calculating manner.
Healthy modes	
Healthy Adult	Thinks about himself in a balanced, realistic manner. Is aware of his own needs and feelings; realistically evaluates situations and thinks about how he can fulfill his needs in a productive, appropriate, and well-adapted manner.
Happy Child	Acts playful, free, and spontaneous; enjoys having fun and sincerely enjoys people and activities; is open about expressing his happy feelings.

In the forensic ST model, criminal and violent behavior is understood in terms of an unfolding sequence of schema modes (Bernstein et al., 2007; Keulen-De Vos et al., 2014). The events leading up to the crime are often initiated by child modes, for example, situations in which someone feels abandoned, humiliated, lonely, or angry, or acts on his or her impulses. These child modes lead to an escalating sequence of modes, which usually culminate in overcompensatory modes, which occur during the commission of antisocial behavior. For example, a patient's partner refuses to have sex with him or her, leaving the patient feeling inferior (Humiliated Child mode), frustrated (Impulsive Child mode), and angry (Angry Child mode). To cope with these feelings, the patient overcompensates, switching to a Self-Aggrandizer mode in which feelings of sexual arousal and power dominate. The patient walks the streets, searching for a victim (Predator mode). The patient randomly knocks on the doors of houses, until a woman answers. The patient then proceeds to talking his/her way into

the house (Conning and Manipulator mode) and violently forces the woman onto the ground and threatens to kills her if she does not cooperate (Bully and Attack mode).

The forensic ST model also provides a framework to understand and treat criminal and violent behavior (Figure 41.1). In this model (Bernstein & Nentjes, 2015) maladaptive schema modes are considered the internal, or psychological, risk factors that increase the likelihood of antisocial behavior, while healthy modes are considered internal protective factors that decrease its likelihood. Schema modes are elicited by the activation of early maladaptive schemas and maladaptive coping responses, which themselves developed in childhood due to the influence of risk factors (e.g., genetic predisposition, childhood abuse, neglect, abandonment, exposure to family or community violence) and protective factors (e.g., genetic predisposition, supportive families and communities, economic opportunities). The likelihood of criminal and violent behavior at a particular moment is determined by the relative activation of maladaptive and healthy modes. The greater the activation of maladaptive modes, relative to healthy modes, the greater the risk for antisocial behavior becomes. External risk factors in the patient's current environment, such as exposure to antisocial peers, lack of employment opportunities, and discrimination, and external protective factors, such as current social support, interact reciprocally with schema modes. They can influence schema modes, or be influenced by them. For example, exposure to antisocial peers may increase the strength of maladaptive modes, while the presence of maladaptive modes may increase the likelihood that one will seek out antisocial peer groups. These external risk and protective factors can therefore operate on antisocial behavior via their influence on schema modes (i.e., indirect, or mediating factors) or by other mechanisms.

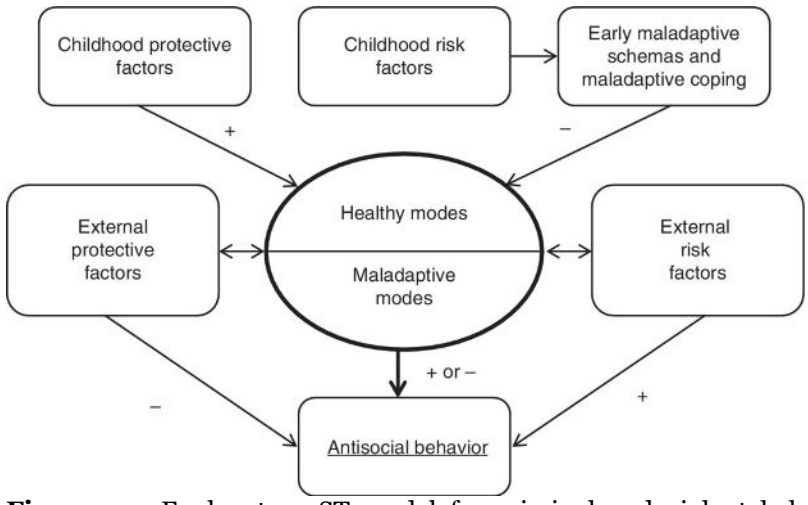

Figure 41.1 Explanatory ST model for criminal and violent behavior. Adapted from Bernstein and Nentjes (2015). *Note.* +: increases risk of antisocial behavior; –: decreases risk of antisocial behavior.

ST Practice

ST Phases of Treatment

ST consists of two broad phases. In the assessment and case conceptualization phase, the therapist uses the concepts of early maladaptive schemas, coping responses, and schema modes to form an understanding of the patient's maladaptive behavior and its origins. During this phase, the therapist also provides psychoeducation, teaching the patient about ST concepts, and helping him or her to apply them to him- or herself. The therapist teaches the patient the "language" of ST, so that the patient can discuss problematic situations that occur inside and outside the therapy sessions in a non-judgmental, accepting way. In the schema change phase, the therapist uses a variety of techniques to reduce the strength of early maladaptive schemas, maladaptive

coping responses, and schema modes, with the goal of breaking dysfunctional behavior patterns and initiating healthier forms of coping, so that the patient can get his or her emotional needs met in more productive ways.

ST Techniques

ST utilizes a number of techniques to change early maladaptive schemas, maladaptive coping responses, and schema modes. These techniques are summarized in Table 41.2.

Table 41.2 Schema Therapy Techniques

Limited re-parenting—Providing for some of the patient's unmet or frustrated basic emotional needs, through the therapy relationship.
Empathic confrontation—Confronting the patient in a compassionate way about his maladaptive patterns, as observed both within and outside of the therapy sessions.
Here and now therapy relationship—Carrying out interventions in the "here and now" interactions between the therapist and patient (e.g., empathically confronting a patient about his behavior toward the therapist).
Cognitive techniques—Challenging distorted beliefs (e.g., early maladaptive schemas) through thought records, schema dialogues, schema flash cards, and other exercises.
Experiential techniques—Reprocessing the emotional components of early maladaptive schemas and schema modes through exercises such as role-playing and imagery re-scripting.
Behavioral techniques—Modifying maladaptive behaviors by practicing healthier alternative behaviors both inside and outside of therapy sessions.
Schema mode work—Combining any of the above techniques with an emphasis on schema modes, for example, by using schema mode "language" in carrying out the interventions (e.g., "I see a side of you right now that …").

In ST for patients who present with less severe personality disorders, cognitive techniques are often used in the early stage of the therapy to help achieve more intellectual distance from early maladaptive schemas. The patient is able to recognize that she or he has schemas, and that when they are triggered, they distort perceptions of people and situations. Nevertheless, this intellectual distance usually isn't sufficient, as she or he is still liable to become emotionally distressed when the schemas are triggered. ST then turns to emotion-focused, experiential techniques to reprocess the emotional components of schemas. For example, in role-playing techniques, patients can learn to "talk back" to their schemas, counteracting their negative messages. Imagery re-scripting is a powerful experiential technique, where patients reprocess painful experiences from the past that are triggered by current situations. The patient is asked to close his or her eyes, and vividly re-imagine a current, troubling situation. The therapist then asks the patient to let go of the image of the current situation, but hold on to the emotion associated with it, and allow a situation from childhood to come to mind that felt the same way. The therapist "re-scripts" the childhood situation, altering aversive elements to meet some of the child's basic needs (e.g., warmth, protection, attention). Reprocessing painful childhood memories in this way often leads to decrease in schematic activation, including the emotional components of schemas. Cognitive and emotion-focused techniques lay the groundwork for the introduction of behavioral techniques, which focus on breaking maladaptive behavior patterns. For example, the therapist can have the patient practice new, healthier behaviors through role-playing exercises during sessions, and give behavioral homework assignments between sessions (e.g., facing feared situations).

Adaptation of ST for Forensic Patients

A number of important modifications of ST are needed when working with more severe PD patients, such as those with antisocial, narcissistic, or borderline PD, who are frequently seen in forensic settings (Leue, Borchard, & Hoyer, 2004; De Ruiter & Trestman, 2007). First, we emphasize schema modes, rather than early maladaptive schemas, in our work with forensic patients. Because most forensic patients are unable or unwilling to expose their emotional vulnerability, it is often difficult, particularly early in the therapy, to discuss early maladaptive schemas with the patients. On the other hand, most of them can recognize their schema modes, which are more easily observed in overt behavior. For example, we use the term, "a side of you" or "a part of you" to talk about the patient's tendency to be detached ("the side of you that avoids feelings"), mistrustful ("the side of you that is alert"), or self-aggrandizing ("the side of you that puts yourself above other people"). Second, considerable time and attention needs to be invested in slowly building an emotional bond between therapist and patient. As treatment in forensic mental health settings is usually court mandated, patients often lack motivation for treatment. Also, interpersonal difficulties are common within offender populations, with offenders having higher levels of hostility, self-centeredness, and self-defeating behavior (Ross, Polaschek, & Ward, 2008). These interpersonal difficulties, and the fact that many offenders grew up in insecure environments (e.g., Bohle & de Vogel, 2017) causing insecure attachment (Timmerman & Emmelkamp, 2006; Van IJzendoorn et al., 1997), can obstruct the therapeutic alliance or cause ruptures in the therapeutic bond (Watson, Thomas, & Daffern, 2015). In less severe cases, the patient accepts the therapist's provision of limited re-parenting at face value. She or he experiences it as the therapist's providing something that is needed and was missed out on as a child. Forensic patients, on the other hand, often react with suspicion to the therapist's attempts to form a bond. They keep their guard up, using a variety of modes to keep the therapist at a distance: a *Detached Protector* mode that avoids emotional contact; a *Self-Aggrandizer* mode that devalues the therapist; a *Bully and Attack* mode that keeps the therapist on the defensive; and so forth. The therapist persists in focusing on the patient's unmet emotional needs, and uses schema mode work to empathically confront the modes that are blocking therapeutic progress. The goal of these interventions is to switch, or "flip," the patient from maladaptive modes into ones that are more therapeutically productive: the *Healthy Adult* mode, where the patient can self-reflect and initiate healthier forms of coping, and modes involving painful emotions such as shame, fear, loneliness, or abandonment. The therapist's task isn't easy—it often takes a year or more before more severe patients are beginning to lower their guard, and share their emotional sides more easily. In forensic outpatient settings, where patients often have less severe PD pathology, and in some forensic youth settings, forming a therapeutic bond may occur more quickly, and ST can be implemented over shorter periods of time, with treatment typically lasting from 1 to 2 years.

Although forensic patients are often described as unmotivated (Howells & Day, 2007; Sainsbury, Krishnan, & Evans, 2004), research supports the idea that motivation for treatment is a dynamic, rather than a static, process (Drieschner, Lammers, & Van Der Staak, 2004; Martens, 2000). In ST, we view the patient's fluctuating motivation in terms of the schema modes that block therapeutic progress—for example, a *Detached Protector* mode that blocks feelings; a *Self-Aggrandizer* mode that attempts to dominate and denigrate the therapist; or a *Paranoid Overcontroller* mode that is alert for signs of the therapist's untrustworthiness. There will always be a struggle between the patient's need to preserve his or her dysfunctional modes, which feel safe and familiar, and his or her healthy side, which sees their disadvantages. Similar to motivational interviewing (Hettema, Steele, & Miller, 2005; Miller & Rollnick, 2012), the therapist avoids getting into a struggle with the patient, and instead explores the advantages and disadvantages of the modes, helping the patient to weigh them for him- or herself. The therapist continually monitors the patient's motivation, which can fluctuate throughout the course of treatment, and uses mode work whenever necessary to enhance it.

We view patients' crime scenarios as involving an unfolding sequence of schema modes, often triggered by vulnerable emotions, impulsivity, or anger; usually followed by the use of substances to either soothe painful emotions or reduce inhibitions to criminal behavior; and culminating in criminal or violent acts which often involve over-compensatory coping, feelings of power or aggression to compensate for feelings of helplessness, frustration, or humiliation. We help patients to understand these patterns using a modification of the familiar antecedents-behaviors-consequences (ABC) model of behavioral analysis (Carr et al., 1994). Situations (antecedents) trigger schema modes, which involve clusters of cognitions, emotions, and coping responses (i.e., behaviors), and which in turn lead to certain consequences. For example, a patient whose girlfriend leaves him might first experience painful feelings of abandonment (*Abandoned Child* mode), which

lead to drug or alcohol use as an attempt at self-soothing (*Detached Self-Soother* mode). These intoxicated states disinhibit impulses and anger (*Impulsive* and *Angry Child* modes), leading to over-compensatory attempts at coping, for example, by stalking, threatening, and attacking his victim (*Bully and Attack* mode). In these overcompensatory states, the patient no longer feels helpless and abandoned; instead, she or he feels powerful and in control.

Because some forensic patients are emotionally detached (Timmerman & Emmelkamp, 2006), activating their emotions so that they can be reprocessed is of critical importance. In the structured circumstances of forensic settings, patients who use avoidant coping strategies, such as detaching from emotions, are often mistakenly viewed as healthy. For example, they may be able to avoid getting into conflicts with other patients or staff by spending their time in isolated activities, and avoiding people and situations that might trigger them. However, while these strategies have some adaptive aspects, they typically have an all-or-nothing quality; when unable to avoid, these patients can often act out explosively. In forensic ST, the therapist uses experiential techniques to evoke and reprocess the patient's early maladaptive schemas—themes such as abandonment, emotional deprivation, mistrust, shame, and social isolation, that, when triggered, lead to criminality or violence. By decreasing the severity of these schemas, the risk for future crime and violence is diminished.

In the early phase of forensic ST (first year, roughly, in hospitalized forensic patients), the goals of therapy are to assess and conceptualize patients' self-defeating patterns, including criminal and violent behavior, in terms of early maladaptive schemas and schema modes; to educate patients about their schema modes; to enhance their motivation using schema mode work; and to use limited re-parenting to slowly build up the therapeutic relationship. In the middle phase (roughly the second year), the emphasis shifts to using experiential techniques and working within the safety of the therapeutic relationship to reprocess patients' early maladaptive schemas and schema modes. In this phase, cognitive techniques, such as the ABC method (Carr et al., 1994), are also used to help the patient recognize the patterns that lead to criminal and violent behavior. In the final phase (roughly the third year), the emphasis is placed on initiating and maintaining behavioral changes and beginning the process of reintegrating into the community. Techniques like role-playing and behavioral homework assignments are used to practice healthy forms of coping. When patients are triggered in new situations, for example, at work or at home outside of the hospital, these situations are analyzed to deepen the patient's understanding of his or her schemas and modes, and experiential techniques are used to further reprocess his or her emotional triggers. Ultimately, the goal of forensic ST is to reduce the early maladaptive schemas and maladaptive schema modes that represent psychological risk factors for crime and violence, and to build up the patient's healthy schema modes, which represent protective factors.

Empirical Support

There is a considerable body of evidence validating the ST theoretical model in non-forensic populations, including the concepts of early maladaptive schemas and schema modes (Jovev & Jackson, 2004; Lobbestael, Arntz, & Sieswerda, 2005; Lobbestael, Van Vreeswijk, & Arntz, 2008; Nordahl, Holthe, & Haugum, 2005), and supporting the effectiveness of ST in (non-forensic) patients with borderline PD and Cluster C PDs (Bamelis et al., 2014; Giesen-Bloo et al., 2006; Gude et al., 2001; Nadort et al., 2009). More recently, this work has been extended to the forensic field. Chakhssi and colleagues (Chakhssi, Bernstein, & Ruiter, 2014) examined the association of early maladaptive schemas with facets of psychopathy. Personality-disordered offenders (N = 124) were assessed with the Psychopathy Checklist—Revised (PCL-R; Hare & Vertommen, 1991) and the Young Schema Questionnaire (YSQ; Young, 1998). Results showed that the antisocial and lifestyle facets of the PCL-R were significantly related to particular schemas, such as mistrust/abuse and insufficient self-control. Early maladaptive schemas were not related to the affective and interpersonal facets of the PCL-R. A second study (Chakhssi, Ruiter, & Bernstein, 2013) examined the explanatory value of schemas in 23 child sex offenders, 19 sex offenders against adults, and 24 non-sexual violent offenders who were assessed with the PCL-R and YSQ (Hare & Vertommen, 1991; Young, 1998). Results showed that early maladaptive schemas related to abandonment, social isolation, subjugation, shame, and self-sacrifice were more prevalent in child sex offenders compared to non-sexual offenders. Moreover, sex offenders who typically victimized

children scored higher on the social isolation schema, compared to sex offenders who typically victimized adults (Chakhssi et al., 2013).

Keulen-De Vos and colleagues (2016) investigated the relationship between schema modes and offense patterns by examining criminal records of 95 offenders with Cluster B personality disorders, including psychopathy. Results showed that (a) criminal behavior was usually preceded by modes involving emotional vulnerability (vulnerable child mode) and loneliness (lonely child mode), as well as states of intoxication (detached self-soother mode); (b) followed by an escalating pattern of anger and impulsivity (angry and impulsive child mode), that is, these modes were present in the events leading up to the crime and increased over time during the crime itself; and (c) criminal behavior was characterized by overcompensatory modes, such as instrumental aggression (Predator mode) and intimidation (Bully and Attack mode), and an absence of emotional vulnerability. Furthermore, schema modes were predictive of institutional transgressions and were associated with facets of psychopathy on the PCL-R (Keulen-De Vos et al., 2016).

A recently completed RCT examined the effectiveness of ST in seven forensic hospitals in the Netherlands (Bernstein, 2016). Male patients (N = 103) with antisocial, borderline, narcissistic, or paranoid PD, or Cluster B PD not otherwise specified (PDNOS; American Psychiatric Association, 2000) were randomly allocated to either 3-years of ST or TAU. Fifty four percent of the patients had significant levels of psychopathy (PCL-R ≥ | 25) and 22% were highly psychopathic (PCL-R ≥ | 30). Nearly all of the patients were sentenced to forensic treatment for (sexual or non-sexual) violent offenses. Patients were assessed at baseline and repeatedly at 6-month intervals over the course of 3 years, using measures that were not dependent on patients' self-reports for most variables. Results showed that ST patients had significantly superior outcomes compared to those receiving TAU on a broad range of variables, including lowering risks for recidivism and improving strengths and protective factors, improving PD symptoms, reducing early maladaptive schemas, and facilitating the process of reintegrating patients into the community (Bernstein, 2016). Interestingly, there were no differences between treatment conditions with regard to schema modes, which were significantly reduced in both ST and TAU patients. One interpretation of these findings is that ST and TAU both reduce maladaptive emotional states, and improve healthy states, in forensic patients, but through different mechanisms. While patients in both conditions learned healthier coping skills, resulting in improved emotional states, only in the ST patients was this change accompanied by changes in the distorted beliefs about self and others (i.e., early maladaptive schemas) that underlie these states. A 3-year post-treatment follow-up will examine whether ST patients show lower recidivism than patients in the TAU condition.

A recent 7-year case study examined the effectiveness of ST in a psychopathic patient (PCL-R total score = 28.4) who was sentenced to mandatory treatment in a forensic hospital because of a sexual offense. Chakhssi, Kersten, de Ruiter, and Bernstein (2014) report evidence of significant improvement in psychopathic traits, early maladaptive schemas, and risk-related outcomes (i.e., Behavioral Status [BEST]-Index; Reed, Woods, & Robinson, 2000; and HCR-20 V2; Webster, Douglas, Eaves, & Hart, 1997) after 4 years of treatment. Improvement was maintained at 3-year follow-up (Chakhssi, Kersten, et al., 2014). Most impressively, the patient's PCL-R score, which was independently and blindly assessed 7 years after the start of treatment, reduced from 28.4 to 14, which is in the non-psychopathic range. At 3-year post-treatment follow-up, he was working, living with his girlfriend and their new baby, and had not recidivated.

Taken together, these findings provide strong support for the theoretical model on which ST is based, and also for the effectiveness of ST in forensic populations of PD patients, including some psychopathic ones.

Future Directions

Recent developments in forensic ST have focused on enhancing its effectiveness when delivered by a multidisciplinary team, such as teams involving psychotherapists, arts therapists, psychiatric nurses, and other professionals. For example, a study (Van den Broek, Keulen-De Vos, & Bernstein, 2011) investigated the integration of ST with arts therapies, such as drama, movement, art, and music therapy, in a pilot study of 10 forensic PD patients. Results found that patients in the ST condition (N = 6) showed significantly more vulnerable child modes in their arts therapy sessions and psychotherapy sessions, compared to patients

receiving standard arts therapy and psychotherapy (TAU; N = 4), based on videotaped ratings of 40 randomly selected therapy sessions. These findings suggest that ST may be more effective than treatment as usual at accessing vulnerable emotions in forensic PD patients, when ST is delivered in both psychotherapy and arts therapy forms.

Other recent developments include training psychiatric nurses, prison guards, and other disciplines, which often have the most daily interactions with offenders in forensic settings, to deliver ST-like interventions to improve the climate on the treatment ward. Preliminary findings suggest that forensic personnel can learn to recognize schema modes in forensic patients, and use techniques like limited re-parenting, empathic confrontation, and limit setting to create a therapeutic climate that is warmer and more emotionally supportive, while also enforcing limits in a firm but non-punitive manner.

An important aspect of the implementation of ST on forensic wards is the recent introduction of the iModes cards (Bernstein, 2016), in which schema modes are represented visually in cartoon form—a format that is more congruent with the learning style and capacities of forensic patients and staff, which tend to be more visual and less verbal. A recent study found that college students and individuals who were self-referred via an organization for people with PDs, the Personality Disorders Awareness Network (PDAN; Grogan, 2011), could accurately identify the iModes images in terms of the schema modes that they represent (Clercx, Bernstein, Feddes, & Richter, 2016).

Finally, ST has also been offered to adolescent populations, such as youth with externalizing behavior disorders and emerging PDs. In a recent pilot study, Van Wijk-Herbrink (2016; Van Wijk-Herbrink, Broers, Roelofs, & Bernstein, 2017) and colleagues found that four adolescents in residential treatment with externalizing behavior and PDs showed significant improvement in their early maladaptive schemas and schema modes after a mean of 7 months of ST. An RCT is currently in progress to test the effectiveness of ST in this youth residential care population. These pilot findings hold the promise that ST can be delivered during a developmental period, adolescence, when PDs often first crystalize, preventing the development of more serious later antisocial behavior problems.

Conclusion

Schema therapy holds considerable potential for explaining criminal and violent behavior, and related PD pathology, and has received empirical support for its effectiveness in a major RCT in hospitalized male forensic PD patients. Future studies will shed further light on this promising treatment for offenders with personality disorders.

Key Readings

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