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Schema Focused Therapy in Forensic Settings: Theoretical Model and Recommendations for Best Clinical Practice

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Until recently few empirically supported treatments for patients with personality disorders were available. Schema Focused Therapy (SFT) has recently shown efficacy in (non-forensic) outpatients with Borderline Personality Disorder, raising the question if it may also be effective in forensic PD patients. For the past two years, we have been collaborating with Dutch forensic hospitals to adapt the SFT approach to meet the challenges posed by this population. In this article, we present our forensic modification of the SFT theoretical model, and make recommendations for the implementation of SFT in forensic clinical practice.

For the past two years, we have been working with treatment professionals in the Netherlands to adapt and integrate Schema Focused Therapy (also known as "Schema Focused Cognitive Therapy," or "Schema Therapy") (SFT; Young, 1999; Young, Klosko, & Weishaar, 2003) in their work with forensic patients. Our experiences in collaboration with Dutch forensic psychiatric hospitals (known as "TBS clinics")—including giving case conferences and workshops, consulting with treatment staff, supervising therapists, and most importantly, learning from the experiences and creative syntheses of the dedicated clinicians who work at these institutions—provides the knowledge base from which the ideas described in this article were developed.

SFT is an integrative form of psychotherapy combining cognitive, behavioral, psychodynamic object relations, and existential/humanistic approaches (Young et al., 2003), and was developed by Jeffrey Young as a treatment for patients with personality disorders and other difficult to treat problems, who often show poor outcomes in other forms of therapy (Young, 1999; Young et al., 2003). In a multi-center randomized clinical trial that was recently completed in The Netherlands, patients with Borderline Personality Disorder who were given SFT showed substantial improvements in their symptoms and functioning over a three year course of treatment, as well as over the one year follow-up interval (Giesen-Bloo et al., 2006). These results suggest that SFT is an effective treatment for Borderline Personality Disorder, raising the question if it also may be effective in treating severe personality disorders in *forensic patients*. It was in this spirit that we undertook the project of adapting and testing the efficacy of SFT methods in forensic patients with personality disorders.

Personality disorders are highly prevalent in forensic populations (de Ruiter, & Greeven, 2000; Hildebrand & de Ruiter, 2004; Leue, Borchard, & Hoyer, 2004; Rasmussen, Storsaeter, & Levander, 1999; Timmerman & Emmelkamp, 2001). In Dutch forensic hospitals,two thirds to 90% of the patient population has a DSM-IV personality disorder, as ascertained by structured diagnostic interview (de Ruiter, & Greeven, 2000; Hildebrand & de Ruiter, 2004; Timmerman & Emmelkamp, 2001). Anti-social, Narcissistic, Borderline, and Paranoid Personality Disorders are the most prevalent specific personality disorders in this population. Personality disorders pose an increased risk of criminal and violent recidivism (Hemphill, Hare, & Wong, 1998; Hiscoke, Langstrom, Ottosson, & Grann, 2003;

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Jamieson & Taylor, 2004; Putkonen, Komulainen, Virkkunen, Eronen, & Lonnqvist, 2003; Rosenfeld, 2003; Salekin, Rogers, & Sewell, 1996). For example, in a recent study in Britain, forensic patients with personality disorders were seven times more likely to have a subsequent serious offense after release from a high security hospital, compared to patients with other psychiatric problems (e.g., Schizophrenia) (Jamieson & Taylor, 2004). The increased risk of recidivism in psychopathy – a severe variant of Antisocial Personality Disorder – has been well documented (Hemphill et al., 1998; Salekin et al., 1996). Thus, improving treatments for forensic patients with personality disorders should be a major priority.

SFT is being increasingly implemented in forensic settings around the world, including the United States, Canada, Britain, and The Netherlands (Rijkeboer, 2005; Tunnissen & Muste, 2002; Young et al., 2003). The adaptation and integration of SFT into forensic settings poses unique challenges. For one, SFT was not developed as a treatment for forensic populations. In the past, the "typical" patient undergoing SFT was someone with a personality disorder seen in a general psychiatry or psychology ambulatory treatment center or a private practice setting (Young et al., 2003). These ambulatory personality disorder cases overlap only partially with forensic personality disorder patients; clearly, in the latter group, issues such as violence, deception/manipulation, remorselessness, and addiction are far more salient. Moreover, in forensic psychiatric settings, individual therapy is usually delivered in a context in which multiple treatment modalities (e.g., art, music, or drama therapy) and other rehabilitation methods (e.g., vocational and educational training) are employed (de Ruiter, 2000). Finally, in forensic settings, patients are either incarcerated or, if treated in ambulatory settings, under strict supervision (e.g., parole or probation).

Thus, the theoretical model and treatment methods on which SFT was originally based require adaptation to meet the specific requirements of forensic populations. In this article, we present our adaptation of the SFT theoretical model for forensic patients, along with our recommendations for best practice in the implementation of SFT in forensic settings (Table 1). Because SFT is a relatively new form of psychotherapy, and is only now beginning to be used in forensic institutions, there are as yet no established standards for how SFT should be implemented in the complex organizational environment of a forensic psychiatric hospital. We offer our recommendations as proposals to stimulate discussion among treatment professionals about the various obstacles and issues that arise in transferring SFT from the outpatient psychiatric clinic environment to the world of forensic mental health practice.

THE ORIGINAL SFT MODEL: EARLY MALADAPTIVE SCHEMAS AND MALADAPTIVE COPING RESPONSES

In Young's original SFT model (Young, 1999; Young et al., 2003), Early Maladaptive Schemas (EMS's) were the basic units of analysis. EMS's are chronic, maladaptive themes or patterns that originate in adverse childhood experiences and early temperament; Young has identified 18 such patterns, such as Abandonment, Abuse/Mistrust, and Defectiveness (see Table 2). For example, an Abandonment Schema involves the expectation that one will inevitably be abandoned in close relationships. These EMS's are deeply held convictions. They are like absolute truths that guide people's perceptions and behavior. For example, someone with an Abandonment Schema is certain that he will be abandoned. It is not a matter of "if" one will be abandoned; it is a matter of "when" one will be abandoned.

When EMS's are triggered, they evoke powerful emotions, such as sadness, fear, and anger. Young hypothesized that people cope with schematic activation in 3 broad ways: Schema Surrender, Schema Avoidance, and Schema Over-Compensation (Young, 1999; Young et al., 2003). Schema Surrender means giving into a schema. For example, someone with an Abandonment Schema may unconsciously be attracted to the very kinds of people who are likely to abandon him or her. When the patient is rejected, it reinforces the belief that abandonment is inevitable. Schema Avoidance means avoiding people or situations that trigger a schema. For example, someone with an Abandonment Schema may avoid close relationships altogether, because he is certain that he will suffer yet another painful abandonment. Finally, Schema Over-Compensation means doing the opposite of the

Table 1
Recommendations for Best Clinical Practice in the Implementation Schema Focused Therapy in Forensic Settings

1. Schema Mode Work is the preferred form of SFT practice with more severe personality disorders.
2. A high PCL-R score is not an exclusion criterion for treatment with SFT.
3. It is advisable to educate professional staff about SFT – its goals, principles, and methods — and to give them a chance to ask questions and raise concerns about SFT.
4. The successful implementation of SFT depends on an institutional environment that is sufficiently safe and supportive of the patient's recovery.
5. SFT 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.
8. The use of psychotropic medications is also not a contradiction for SFT.
9. SFT 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 SFT.
11. The rigors of working with forensic patients make the need for thorough training of SFT therapists imperative.
12. Regular supervision or peer supervision sessions are necessary to insure the effective delivery of SFT in forensic settings.
13. Therapists should have at least 3 years of prior psychotherapy experience before they attempt to master SFT.
14. Competency ratings for therapists should become standard practice, particularly in forensic settings in which the therapists' competency may affect patients' recidivism risk.

schema. For example, someone with an Abandonment schema may over-compensate by leaving a relationship before he can be left himself.

Schema Modes in Severe Personality Disorder

Over time, Young found that standard SFT techniques emphasizing EMS's and coping responses were of limited effectiveness in treating severe personality disorders (Young et al., 2003). One reason for this is that patients with severe personality disorders often have so many EMS's that discussing them all becomes unwieldy. Second, people with severe personality disorders have relatively unintegrated personalities. As a result, they often switch rapidly between emotional states, making it difficult for therapists to know how to target their interventions. Young developed Schema Mode Work as a more manageable and effective alternative for treating these shifting emotional states (Young et al., 2003).

Schema Mode Work is the preferred form of SFT practice with more severe personality disorders (Guideline 1), such as Antisocial, Borderline, Narcissistic, and Paranoid Personality Disorders, which are the most prevalent personality disorders in forensic settings (e.g., Hildebrand & de Ruiter, 2005). Schema Mode Work comprises a set of techniques that enables the therapist to work with the rapidly fluctuating emotional states and coping responses that are so characteristic of severe personality disorders. Schema Modes are defined as the emotional state or "part of the person" that dominates a person's thoughts, feelings, and behavior at a given moment in time (Young et al., 2003). Young has identified 11 Schema Modes, which he

Table 2
Early Maladaptive Schemas and Schema Domains

Disconnection and Rejection	
1. Abandonment/Instability	The expectation that one will inevitably be abandoned
2. Mistrust/Abuse	The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage
3. Emotional Deprivation	The expectation that others won't meet one's need for a normal degree of emotional nurturance, empathy, and protection
4. Defectiveness/Shame	The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects
5. Social Isolation/Alienation	The feeling that one is always an outsider, different and alienated from other people
Impaired Autonomy and Performance	
6. Dependence/Incompetence	Expectation that one can't handle everyday responsibilities without considerable help from others.
7. Vulnerability to Harm or Illness	Exaggerated fear that imminent catastrophe will strike at any time and that one cannot prevent it.
8. Enmeshment/Undeveloped Self	Excessive emotional involvement and closeness with others at the expense of full individuation or normal social development.
9. Failure	The belief that one has failed, or will inevitably fail, or is fundamentally inadequate in areas of achievement
Impaired Limits	
10. Entitlement/Grandiosity	The belief that one is superior to others, entitled to special rights and privileges, or bound by normal rules of social reciprocity
11. Insufficient Self-Control/ Self-Discipline	Pervasive difficulty or refusal to exercise self-control and frustration tolerance to achieve goals.
Other-Directedness	
12. Subjugation	Excessive surrendering of control to others because one feels coerced, to avoid anger, retaliation, or abandonment
13. Self-Sacrifice	Excessive focus on voluntarily meeting the needs of others at the expense of one's own gratification.
14. Approval-Seeking/ Recognition-Seeking	Excessive emphasis on gaining approval, recognition, or attention from other people
Over-vigilance and Inhibition	
15. Negativity/Pessimism	A pervasive, lifelong focus on the negative aspects of life (e.g., pain, death, loss) while minimizing the positive or optimistic aspects
16. Emotional Inhibition	The excessive inhibition of spontaneous action, feeling, or communication
17. Unrelenting Standards/ Hyper criticalness	The belief that one must strive to meet very high internalized standards of behavior and performance
18. Punitiveness	The belief that people should be harshly punished for making mistakes

Note: Adapted from Young, Klosko, & Weishaar, 2003

groups into 4 categories: Child Modes, Dysfunctional Coping Modes, Maladaptive Parent Modes, and Compensatory Modes (Young et al., 2003). Definitions are provided in Table 3.

In severe personality disorders, Schema Modes are relatively dissociated from each other; the patient lacks a strong Healthy Adult Mode that is aware of the patient's various emotional states and can moderate and integrate them, bringing them under deliberate control (Young et al., 2003). For that reason, patients with severe personality disorders often "flip" between modes, both within therapy sessions and outside of them. This mode flipping occurs automatically and often without conscious awareness, either of the emotional state itself or of its consequences for the patient's well-being. For example, a patient with Antisocial Personality Disorder may fluctuate between emotionless detachment ("Detached Protector Mode"), compulsive efforts at self-soothing through drug or alcohol use or other addictive behavior ("Detached Self-Soother Mode"), primitive rage reactions in response to narcissistic injuries or abandonment ("Angry Child Mode"), grandiose devaluation ("Self-Aggrandizer Mode"), cunning attempts to con and manipulate ("Conning Mode"), attempts to intimidate or bully ("Bully and Attack Mode"), and ruthless acts of violence aimed at eliminating a threat, rival, or obstacle ("Predator Mode"). The goal of Schema Mode Work is to help the patient moderate or eliminate his various maladaptive Schema Modes, and to develop a stronger Healthy Adult Mode that can help the patient meet his basic emotional needs in a more adaptive and successful manner.

ADAPTING THE SCHEMA MODE THEORETICAL MODEL FOR FORENSIC PATIENTS

We propose that the Schema Mode model be expanded to include 4 new Schema Modes that appear to be common in forensic patients, beyond the 11 original modes that were proposed by Young and colleagues (Young et al., 2003). The 4 new modes are Angry Protector Mode, Predator Mode, Conning and Manipulative Mode, and Over-Controller Mode (Obsessive and Paranoid subtypes) (see also Table 3).

Angry Protector Mode is a state in which a patient uses anger to protect himself from perceived threat or danger. In Angry Child mode, from which Angry Protector Mode must be distinguished, the patient vents his rage in an uncontrolled display of emotion, usually in response to a perceived injustice. In contrast, Angry Protector mode has the goal of creating a "wall of anger" that keeps the threat at a safe distance.

Predator Mode is a state in which a patient focuses on eliminating a threat, rival, obstacle, or enemy in a cold, ruthless, and calculating manner. Predator Mode must be distinguished from Angry Child Mode and Angry Protector Mode, both of which involves displays of anger, and Bully and Attack Mode, which involves attempts to bully or intimidate others to achieve a position of superiority.

Conning and Manipulative Mode is a state in which a patient cons, lies, or manipulates in a manner designed to achieve a specific goal, which either involves victimizing others or escaping punishment.

Table 3
Schema Modes (Including 11 Original Schema Modes and 4 New Forensic Modes)

Child Modes Involve feeling, thinking, and acting in a "child-like" manner	
1. Vulnerable Child (Abandoned, Abused, or Humiliated Child)	Feels vulnerable, overwhelmed with painful feelings, such as anxiety, depression, grief, or shame/humiliation.
2. Angry Child	Feels and expresses uncontrolled anger or rage in response to perceived or real mistreatment, abandonment, humiliation, or frustration; often feels a sense of being treated unjustly; acts like a child throwing a temper tantrum.

... continued

Table 3 (continued)

3. Impulsive, Undisciplined Child	Acts like a spoiled child who "wants what he wants when he wants it," and can't tolerate the frustration of limits.
4. Lonely Child	Feels lonely and empty, as if no one can understand him, sooth or comfort him, or make contact with him.
Dysfunctional Coping Modes	
Involve attempts to protect the self from pain through maladaptive forms of coping	
5. Detached Protector	Uses emotional detachment to protect one from painful feelings; is unaware of his feelings, feels "nothing," appears emotional distant, flat, or robotic; avoids getting close to other people
6. Detached Self-Soother/Self-Stimulator	Uses repetitive, "addictive," or compulsive behaviors, or self-stimulating behaviors to calm and sooth oneself; uses pleasurable or exciting sensations to distance oneself from painful feelings.
7. Compliant Surrenderer	Gives in the to real or perceived demands or expectations of other people in a anxious attempt to avoid pain or to get one's needs met; anxiously surrenders to the demands of others who are perceived as more powerful than oneself.
8. Angry Protector	Uses a "wall of anger" to protect oneself from others who are perceived as threatening; keeps others at a safe distance through displays of anger; anger is more controlled than in Angry Child Mode
Maladaptive Parent Modes	
Involve internalized dysfunctional parent "voices"	
9. Punitive, Critical Parent	Internalized, critical or punishing parent voice; directs harsh criticism towards the self; induces feelings of shame or guilt
10. Demanding Parent	Directs impossibly high demands toward the self; pushes the self to do more, achieve more, never be satisfied with oneself.
Over-Compensatory Modes	
Involve extreme attempts to compensate for feelings of shame, loneliness, or vulnerability	
11. Self-Aggrandizer Mode	Feels superior, special, or powerful; looks down on others; sees the world in terms of "top dog" and "bottom dog;" shows off or acts in a self-important, self-aggrandizing manner; concerned about appearances rather than feelings or real contact with others
12. Bully and Attack Mode	Uses threats, intimidation, aggression, or coercion to get what he wants, including retaliating against others, or asserting ones dominant position; feels a sense of sadistic pleasure in attacking others
13. Conning and Manipulative Mode	Cons, lies, or manipulates in a manner designed to achieve a specific goal, which either involves victimizing others or escaping punishment
14. Predator Mode	Focuses on eliminating a threat, rival, obstacle, or enemy in a cold, ruthless, and calculating manner.
15. Over-Controller Mode (paranoid and obsessive compulsive types)	Attempts to protect oneself from a perceived or real threat by focusing attention, ruminating, and exercising extreme control. The Obsessive type uses order, repetition, or ritual. The Paranoid type attempts to locate and uncover a hidden (perceived) threat.

Note: Modes 1-7, and 9-12, are adapted from Young, Klosko, & Weishaar, 2003

The patient may assume a false identity, give misleading information, or behave in a seductive, manipulative, or theatrical manner, to achieve his ends.

In Over-Controller Mode, the patient's emotional state involves a narrowing of attention along with obsessive rumination in an attempt to protect oneself from a perceived threat. In the Obsessive subtype, the patient attempts to control a source of danger through the use of order, repetition, or ritual. In the Paranoid subtype, the patient attempts to seek out and therefore control a source of danger or humiliation, usually by locating and uncovering a hidden (perceived) threat.

These additions to the SFT conceptual model may help both therapists and patients to recognize and work with the most common Schema Modes seen in forensic patients with personality disorders. In our experience, Schema Modes often play themselves out in a predictable pattern. In some instances, these temporal sequences of unfolding Schema Modes may help to explicate the events leading up to and culminating in the commission of crimes.

Case Example #1

Omar, a man with Narcissistic and Paranoid Personality Disorder, was convicted of murder and given treatment in a TBS clinic. His crime grew out of his obsession with a female co-worker, someone he hardly knew but on whom he had developed a pathological fixation. He was a very intelligent man of Middle Eastern background, who grew up in a lower-income neighborhood in the Netherlands. His parents were very religious, strict, and conservative. They insisted that he improve his future prospects through hard work and education. He became a diligent student, earning high marks in his courses. At the same time, he felt like a social outcast in Dutch society, because of his family's poverty and foreign background, and his own social awkwardness. Yet, he also felt secretly superior to those around him. He dreamed of marrying a beautiful, white (non-Middle Eastern) Dutch girl who would inspire envy in others, and show everyone that he had "made it" in the mainstream Dutch world.

As a teenager, Omar had become obsessed with a blond haired, blue eyed classmate. When she rejected his advances towards her, he stalked her for several months. Some years later, when he was in his early 20's, the same pattern recurred with his co-worker, another blond Dutch woman. When his co-worker refused to go out with him, he felt deeply humiliated (Humiliated Child Mode). He ruminated about his rejection, feeling that it wasn't fair. "If she would just get to know me, she would eventually agree to become my girlfriend." At such moments, he believed that he would always feel like an outsider and loser. Eventually, he resolved to pursue the woman of his dreams even more diligently. After making this decision, his mood shifted from shameful and dejected to powerful and superior. He fantasized about the sense of triumph he would feel when he proudly showed off the beautiful, blond Dutch girl on his arm. Thus, his shift in mood represented a "flip" from Humiliated Child Mode to Self-Aggrandizer Mode, a mode in which feelings of being special and superior compensate for underlying feelings of inferiority.

In this grandiose state, he pursued his love-interest even more doggedly. He called her frequently at home, asking her to go out with him, sent her small gifts, and even spoke to her friends, trying to persuade them to help him in his quest to woo her. At first, the woman rebuffed him politely. He ignored these signs and continued his pursuit. Eventually, however, as her anxiety and irritation grew, she told him in no uncertain terms that she was not interested in him. He became enraged. He angrily ruminated over the humiliating injustice she had perpetrated on him. Rather than respecting the woman's wishes, he began aggressively stalking her. When she angrily told him to leave her alone, he became verbally abusive towards her. This shift in mood from grandiose euphoria to hostility represented another switch in schema modes from Self-Aggrandizer to Bully and Attack Mode. He would use threats and aggression to get what he wanted. Not surprisingly, his aggressive behavior only prompted further rejections, leading to further escalations of the patient's aggressive behavior.

At this point, the patient's thinking took a paranoid turn. He became convinced that the woman was deliberately trying to humiliate him, and that her friends knew about this and were laughing at him behind his back. He began looking for the person or persons who were behind the "conspiracy." This turn towards paranoia represented another mode

switch, this time to Paranoid Over-Controller Mode – a mode in which attention becomes focused in an attempt to find the source of a perceived threat or humiliation. Eventually, the patient believed that he had located the source of the problem. He was certain that it was the woman's best friend who had turned her against him. His feelings of anger and shame were replaced by cold calculation as he formulated a plan for "getting rid of" the person who was standing in his way. He was sure that the woman he desired would fall in love with him, if only he was given the chance he deserved. He was certain that her best friend could influence her in this direction. If she refused to help him, he would kill her.

This turn towards cold anger and calculation represented a final mode shift — to Predator Mode. In Predator Mode, a perpetrator focuses in a cold, ruthless manner on eliminating a threat or obstacle to getting what he wants. The patient carried out his plan. When the friend refused to help him, he stabbed her to death. When asked about his motives for this gruesome crime, he said that the murder of her best friend was the only way to make the woman he desired feel the pain that he himself had been feeling. In effect, it was an act of revenge for the humiliating rejection he had suffered. Thus, to his mind, his crime had righted the scales of justice, restoring his lost sense of pride and dignity. It was not an act he regretted.

Thus, the patient's otherwise "senseless" crime can be re-constructed and made intelligible by tracking the fluctuations in his Schema Modes – shifts in psychological state that led the patient from humiliation (Humiliated Child Mode), to a failed attempt at grandiose over-compensation (Self-Aggrandizer Mode), to anger and aggression (Bully and Attack Mode), to a desperate attempt to locate the sources of his humiliation (Paranoid Over-controller Mode), and finally, to a cold and ruthless plan to eliminate the source of the problem, or, barring that, to take revenge (Predator Mode). In people with severe personality disorders and a propensity to violence, these schema modes often play themselves out in a predictable pattern with tragic consequences. Thus, the schema modes are closely connected to the patient's risk for violence and recidivism. By targeting and ameliorating the patient's schema modes, SFT may achieve a reduction in the patient's risk for future crime and violence.

Psychopathy: Schema Mode Conceptualization

From a Schema Mode perspective, we would hypothesize that highly psychopathic patients make prominent use of some of the most maladaptive and destructive Schema Modes, particularly Predator Mode, Conning Mode, Self-Aggrandizer Mode, and Bully and Attack Mode. When in Predator Mode, the psychopathic patient engages in a cold, ruthless, remorseless, and calculated attempt to eliminate whoever or whatever stands in the way of his getting what he wants – the type of behavior we often think of as indicating a "true" psychopath.

Predator Mode can be thought of as a type of survival mode – an extreme compensatory mode that reflects a view of the world as a contest for "survival of the fittest," divided into victims and victimizers, prey and predators. Our working hypothesis is that Predator Mode typically arises in childhood under conditions of extreme threat and/or humiliation to the child, often in combination with an environment where others model predatory behavior, and in which predatory attitudes and behaviors are explicitly or implicitly valued and communicated (Jaffee, Caspi, Moffitt, & Taylor, 2004; Lang, af Klinteberg, & Alm, 2002; Marshall & Cooke, 1999; Poythress, Skeem, & Lilienfeld, 2006; Weiler, & Widom, 1996). The child learns that he can command respect from others and overcome his feelings of fear and shame by becoming a predator: blocking out his feelings, including feelings of compassion and remorse; learning to recognize weaknesses in others, while showing no signs of weakness himself; asserting his power and authority whenever possible, especially through the use of force, to get others to fear him; and learning to use deception, charm, and manipulation to ingratiate himself with potential victims. This process is facilitated by an escalating series of violent acts in which he demonstrates his power and fearlessness to himself and others, and progressively desensitizes himself to any feelings of empathy or remorse. We hypothesize that this mode is more likely to develop in individuals with a genetic propensity towards emotional callousness (Taylor, Loney, Bobadilla, Iacono, & McGue, 2003; Viding, Blair, Moffitt, & Plomin, 2005) – thus, an interaction between genetic vulnerability and adverse life experiences (e.g., Caspi et al., 2002).

Case Example #2

As a boy, Carlos, a psychopathic patient, was repeatedly abused and bullied by his psychopathic father. His father insisted that he must always prove that he was "a man" – tough, strong, able to withstand any amount of pain without flinching, never backing down from a fight, never allowing others to show any sign of disrespect toward him. Any sign of weakness or vulnerability would make him a "pussy." His father modeled these values by terrorizing his family. He demanded total obedience. His word was law. Any transgression would be punished by terrifying and humiliating beatings.

As a boy, Carlos was an outcast among his peers. He had no close friends, and never fit in with any social group. He had school problems, and was probably learning disabled, hyperactive, and conduct disordered. He was labeled a "bad" kid – a label that formed the basis of his own self-image. He felt lonely and deeply ashamed of himself (Humiliated Child Mode). By the time he was a teenager, the patient had learned that the surest way to survive in his father's world was to imitate him. He regularly used physical force to bully and intimidate his girlfriends (Bully and Attack Mode). He made friends with other delinquent young men who shared and reinforced his predatory world-view and with whom he would regularly victimize others. He began to engage in a variety of crimes, including burglary and drug dealing. His own drug and alcohol use escalated to the point where he was almost always in a substance-induced state of emotional numbness (Detached Protector Mode), enabling him to further detach from feelings such as empathy and compassion that might have inhibited his violent and predatory behavior. Eventually he became an "enforcer" for a local drug lord, carrying out orders that included using threats or force to intimidate others, and sometimes committing cold-blooded killings (Predator Mode). While in Predator Mode, he described himself as, "robotic," "feeling nothing," and focusing completely on his task. It was "just business." Many years later, after a long prison term and, following his release from prison, the patient contracted HIV. He entered a drug treatment program, where he experienced his first extended period of sobriety. Eventually, he became clinically depressed and expressed feelings of remorse for his crimes.

In Hare's popular model, which reflects the predominant view of psychopathy over the past 200 years, psychopathic traits are assumed to be genetically based propensities that are unchangeable (Hare, 1993). The widely used Psychopathy Checklist -Revised ([PCL-R] Hare, 1991), which is based on Hare's trait approach, is based on a static conception of psychopathy as an unchangeable lifetime diagnosis. It is generally assumed that psychopathic patients are untreatable. Surprisingly, there is little solid empirical evidence from well-designed research studies to support this contention (D'Silva, Duggan, & McCarthy, 2004). Emerging evidence suggests that psychopathy is probably a multi-faceted concept, with multiple subtypes and multiple etiological pathways (Edens, Marcus, Lilienfeld, & Poythress, 2006; Taylor, et al., 2004; Viding, et al., 2005). Some of these patients may prove amenable to treatment, and others not. The above considerations suggest that the PCL-R score, while being a good predictor of criminal recidivism (Hemphill et al., 1998; Salekin et al., 1996), should not be considered a predictor of patients' treatability until empirical evidence can determine whether or not some psychopathic patients can be treated. Thus, *a high PCL-R score is not an exclusion criterion for treatment with SFT (Guideline 2).*

Adapting the SFT Treatment Approach for Forensic Patients

SFT incorporates treatment techniques drawn from cognitive, behavioral, psychodynamic object relations, and existential/humanistic therapies (Young, 1999; Young et al., 2003). For example, it uses cognitive techniques to modify patients' maladaptive thoughts about self and others (i.e., Early Maladaptive Schemas); experiential techniques to help patients vent feelings and process the emotions connected with schemas; the therapeutic relationship to provide "corrective emotional experiences" in the context of a close relationship; and behavioral techniques to teach coping skills and break maladaptive behavioral patterns (Young, 1999; Young et al., 2003).

The central treatment concepts in SFT are "limited re-parenting" and "empathic confrontation" (Young, 1999; Young et al., 2003). In limited re-

parenting, the therapist attempts to provide some of the warmth, available, guidance, and support that the patient lacked in childhood. In the SFT model, the guiding premise is that the patient's self-defeating life patterns (e.g. Early Maladaptive Schemas, Schema Modes) grow out of an interaction between his innate temperament and the failure of caregivers to meet his early developmental needs (e.g., for love, understanding, guidance, and protection). With limited re-parenting, the therapist attempts to meet these frustrated or neglected developmental needs within appropriate limits.

In empathic confrontation, the therapist confronts the patient regarding his maladaptive behavior patterns, but in a manner that is empathic and non-threatening (Young, 1999; Young et al., 2003). The SFT conceptual model (i.e., Early Maladaptive Schemas, Coping Mechanisms, and Schema Modes) provides an objective and non-pejorative "language" for accomplishing this. In the first stage of SFT treatment, the therapist introduces the SFT conceptual model and, in collaboration with the patient, spends several sessions assessing the patient's self-defeating life patterns and translating them into SFT terms. Thus, over time, the patient learns to recognize and understand his repeating maladaptive patterns using the SFT concepts. Subsequently, when the patient engages in self-defeating behavior, the therapist is able to confront these patterns using concepts that are emotionally and morally neutral and are easy for the patient to understand.

As noted above, patients with severe personality disorders, such as those often seen in forensic settings, present special challenges because of their fluctuating emotional states. In the SFT model, these states are conceptualized as "Schema Modes" (Young et al., 2003). In addition to developing the Schema Mode conceptual model, which we have already discussed, Young has developed interventions that the therapist uses to target the various Schema Modes when they occur. For example, different types of interventions are required when patients "flip" into Vulnerable Child Mode, Angry Child Mode, or Bully and Attack Mode. Thus, the therapist's awareness of the patient's fluctuating emotional states guides his interventions, which are designed to "flip" the patient out of his maladaptive Schema Modes, and into Schema Modes that are more therapeutically productive (i.e., Vulnerable Child Mode and Healthy Adult Mode). Young et al. (2003) contains a more thorough discussion of Schema Mode treatment techniques for working with severe personality disorders.

Recent research suggests that standard cognitive and behavioral approaches are only of limited effectiveness in forensic patients with personality disorders (Timmerman & Emmelkamp, 2005). SFT may provide a more effective alternative for forensic patients with personality disorders for several reasons. First, its theoretical model provides a conceptual rubric within which the patient and therapist can better understand the meaning behind triggering events. For example, a patient may come to recognize that he is most prone to act out violently when he has experienced perceived abuse, abandonment, or humiliation (e.g., Abused, Abandoned, and Humiliated Child Modes). Thus, the SFT approach may enhance the effectiveness of standard cognitive and behavioral techniques by linking them to the patient's problematic Early Maladaptive Schemas and Schema Modes. Second, SFT incorporates experiential techniques for emotionally re-working schemas that are not found among standard cognitive and behavioral approaches. Third, SFT posits that the therapeutic relationship is a critical agent of change in patients with severe personality disorders whose childhood experiences with caregivers were often inadequate or toxic. This "limited re-parenting" approach is not a feature of usual cognitive or behavior approaches. Finally, Schema Mode Work provides a conceptual framework and set of interventions for managing the fluctuating emotional states of personality disorder patients.

In our own work with therapists in forensic settings, we have found that the SFT treatment approach can be adapted for forensic patients without major adjustments. The main difference is that therapists must be aware of, and become adept at working with, the kinds of Schema Modes that are prevalent among forensic patients (e.g., Bully and Attack Mode), but are less often seen in general psychiatric populations. Thus, the basic SFT approach remains the same, but can be tailored to the therapeutic needs of this challenging population.

IMPLEMENTING SFT IN FORENSIC SETTINGS

A forensic psychiatric institution is a complicated organization in which treatment professionals with varying backgrounds and approaches collaborate towards a specific end: reducing patients' risk of recidivism (de Ruiter, 2000). Whenever a new approach, such as SFT, is introduced into this "mix," it can have ramifications throughout the entire organization. While some treatment professionals may welcome or even embrace new therapeutic developments, others may be confused by, or feel threatened by them. For this reason, *it is advisable to educate professional staff about SFT – its goals, principles, and methods — and to give them a chance to ask questions and raise concerns about SFT (Guideline 3)*. It is important to affirm the value of a multi-disciplinary team approach to forensic treatment in which various therapeutic disciplines play important roles. Moreover, it should be emphasized that SFT is not a panacea.

Delivering SFT as part of a Multi-Disciplinary Treatment Team

One of the most frequent complaints of SFT therapists working in forensic settings is that their "re-parenting" stance puts them at odds with other members of the multi-disciplinary treatment team, who are more punitive and less sympathetic towards patients. One therapist described herself as feeling like a protective "mother lion" who felt frustrated and helpless when her patient was given what she saw as an excessively severe punishment for an infraction. In contrast, the treatment team viewed the therapist as being "duped" by a manipulative patient who had used his charm to form an alliance with her against the rest of the staff. From a SFT perspective, we can understand this kind of situation as a complex group dynamic in which the patient's Schema Modes evoked corresponding Schema Modes in various staff members, including the therapist.

Case Example #3

Jan, a patient with Antisocial Personality Disorder, became caught up in an escalating cycle of defiance and punishment, when his angry refusal to end a session in the gymnasium triggered increasingly severe sanctions by staff. The patient had been physically abused as a child, and had learned to respond to punishment with a smug show of indifference (Angry Protector Mode). Rather than showing contrition, he smirked and turned his back when given a punishment, as if to say, "You may think that you are more powerful than I, but nothing you do can affect me." Not surprisingly, the staff found his defiance enraging, and applied even more stringent punishments in an attempt to set limits on his "uncooperative" behavior. This only provoked further defiance in the patient. This escalating cycle eventually led to the patient's having to spend several weeks in isolation – a punishment that seems disproportionate to the patient's original infraction (i.e., refusing to leave the gymnasium when he was told to do so). Thus, the patient's hostile defiance (Angry Protector Mode) brought out a punitive side in the treatment team (Punitive Parent Mode), initiating a destructive and mutually reinforcing pattern.

In contrast to his defiant behavior towards the treatment team, the patient was able to show his vulnerable side to his therapist, with whom he continued to meet during his period of seclusion. He confided experiencing painful feelings of loneliness and powerlessness (Vulnerable Child Mode). He said that he was desperate to make amends with the treatment team and be allowed to rejoin the clinic community. His attempts to make contact with members of the treatment team had been consistently rebuffed. He felt that he was being mistreated, but couldn't understand the connection between his own behavior and the over-reactions of clinic staff. The therapist felt that the patient's vulnerable emotions were genuine, and tried to intervene on his behalf. However, the rest of the team was unsympathetic.

In her re-parenting role, the SFT therapist must support the patient but at the same time help him to learn to take responsibility for his own behavior. A Schema Mode conceptualization provides an emotionally and morally neutral manner in which these self-defeating patterns can be pointed out to patients. Such punitive situations, though painful to the patient, provide him with an opportunity to recognize his own role in provoking and maintaining these escalating conflicts, and ultimately, to learn to break these patterns. If the therapist attempts to "rescue" the patient by siding with him against the

rest of the treatment team, she may inadvertently deprive the patient of the opportunity to learn from the consequences of his own actions.

At the same time, the treatment team also bears some of the responsibility for ameliorating these difficult interactions. Educating treatment staff in SFT concepts can facilitate the resolution of these conflicts. The Schema Mode model provides team members with an objective and non-threatening means of understanding patients' provocations, as well as their own possible over-reactions to them. Once such situations have been re-framed in SFT terms, they can usually be resolved more easily.

Needless to say, the *successful implementation of SFT depends on an institutional environment that is sufficiently safe and supportive of the patient's recovery (Guideline 4)*. No form of psychotherapy, no matter how skillfully delivered, can be expected to succeed if the institutional milieu is dangerous or cruel. In the SFT model, we would expect that a threatening or harsh institutional environment would reinforce precisely the kinds of maladaptive Schema Modes in forensic patients that SFT is attempting to ameliorate, such as Angry Protector Mode, Bully and Attack Mode, Conning and Manipulative Mode, and Predator Mode. We hypothesize that these modes usually develop as extreme forms of adaptation under conditions, such as severe abuse or neglect, which threaten children's survival. It would not be surprising that these same modes would be evoked later in life in conditions that mimicked their childhood origins. In contrast, an institutional environment that is sufficiently safe, and is perceived by patients as firm but fair, rather than punitive, provides conditions that are favorable to the implementation of SFT. The institution itself is an important aspect of the patient's re-parenting experience. By providing safety, support, and validation, it creates the conditions under which patients can modify their maladaptive behaviors and learn healthier forms of adaptation (i.e., develop a stronger, more adaptive Healthy Adult Mode).

Selecting Patients for SFT

In principle, any personality disorder patient can be treated using SFT. Unlike some other forms of psychotherapy that actively exclude patients who are unable to agree to a treatment contract or are deemed too fragile for a confrontational form of therapy (e.g., Clarkin, Yeomans, & Kernberg, 1999), SFT has no formal exclusion criteria, nor does it seek to treat only "healthier," "higher functioning," "insightful," or "motivated" patients. In fact, *SFT ascribes to the forensic treatment principles of risk, need, and responsivity* (Gendreau, Goggin, French, & Smith, 2006; Wong & Gordon, 2004), *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 (Guideline 5).*

Psychiatric Comorbidity

As a general rule, psychiatric comorbidity (i.e., with Axis I disorders) is not a contraindication for SFT (Guideline 6). Many, if not most, patients with personality disorders have current or past comorbid Axis I disorders, such as mood and anxiety disorders, addictive disorders, eating disorders, dissociative disorders, or somatoform disorders (Kreuger, 2005). Excluding such patients from treatment would leave a very limited number of patients amenable to treatment with SFT. In the case of patients whose presenting problem is an Axis I disorder, the standard procedure is to first treat the Axis I symptoms (e.g., through psychotherapy or medication) before initiating SFT to treat the underlying personality disorder.

Contraindications for SFT. In practice, however, it is important to acknowledge that *there are some comorbid conditions that may be contraindications for SFT, such as low intelligence, neurological impairment, autistic spectrum disorders, and certain psychotic disorders (Guideline 7).* Similarly, severe attentional problems (e.g., Attention Deficit Disorder) or severely impulsive behavior (e.g., Intermittent Explosive Disorder) may limit the patient's ability to participate in SFT. Psychiatric medication may help to ameliorate some patients' difficulties in these areas to the point where they are able to benefit from SFT. Patients with a propensity for psychosis may be vulnerable to decompensation during SFT, because of the more exploratory (e.g., imagery exercises) and confrontational aspects of the treatment. Certainly, patients who are actively psychotic should not undergo SFT until after their psychotic symptoms have remitted. *The use of psychotropic medications is also not a contradiction*

for SFT (Guideline 8). In fact, the prompt use of medication to treat Axis I symptoms may help to stabilize patients in the acute phase of illness and make them more amenable to treatment with SFT.

SFT in dually diagnosed patients

There is a complex interplay between personality disorders and addiction (Verheul, van den Bosch, & Ball, 2005). This inter-relationship is of potentially critical importance for SFT treatment of forensic patients, given the high comorbidity between personality disorders and addictive disorders in forensic populations (Verheul, et al., 2005). For serious addictions (i.e., dependence on "hard drugs" or alcohol), *SFT 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 (Guideline 9).* It would be naïve to presume that SFT alone would be sufficient to combat the powerfully reinforcing effects of addictive substances on behavior, when addicts are in the active phase of their addiction. For active addicts with severe drug or alcohol dependence, cessation or at least substantial reduction of drug or alcohol use must precede any attempt to initiate SFT.

In the SFT model, addictive disorders are usually conceptualized as a form of self-soothing behavior, which patients use to manage their otherwise too painful emotions (Ball, 2004; Young et al., 2003). In Schema Mode terms, addictive behavior usually corresponds to the Detached Self-Soother Mode, wherein patients use addictive or compulsive behavior to enter a state of emotional numbing in which they feel not "nothing," but rather a pleasant state of excitement, high, buzz, bliss, or similar sensations – all of which serve as a self-soothing form of detachment from real feelings. This model obviously bears similarity to the self-medication model of addiction (Khantzian, 1997), in which addictive behavior is hypothesized to act as a self-regulatory mechanism for managing painful emotional states, such as anger, sadness, or anxiety.

When patients spend much of their waking hours under the influence of addictive substances, the emotionally numbing effects can be profound, making it virtually impossible for the patient to experience any real feelings at all (Detached Protector Mode). In effect, these patients remain in a Detached Protector Mode nearly all of the time, except during states of withdrawal. Not only does this emotional numbing serve a self-regulatory function, it may enable patients to more effectively detach themselves from "moral" feelings such as empathy, guilt, and shame that under normal circumstances inhibit antisocial behavior. Thus, the emotional detachment that is often so evident in psychopathic patients may also be a consequence of prolonged substance abuse itself. When such patients cease using addictive substances, and have prolonged periods of sobriety, they may begin to experience emotions that are raw, painful, and quite unfamiliar to them.

Diagnosis and Assessment

Careful assessment of patients is an essential precondition for SFT (Guideline 10). SFT is a flexible approach in which the therapist adapts his methods to the patient's problems. The therapist's treatment approach flows directly from his case conceptualization, including DSM-IV Axis I and Axis II diagnoses. If the therapist "misses the boat" by misdiagnosing the patient, the treatment will flounder. Unfortunately, many personality disorder patients are misdiagnosed because of a less than rigorous assessment of Axis II disorders. The clinical impressions of a psychiatrist or psychologist, no matter how experienced, is no substitute for careful evaluation of the DSM-IV criteria using semi-structured diagnostic interviews, which enhance the quality (i.e., reliability and validity) of psychiatric diagnoses (Segal & Coolidge, 2003).

Therapist Training, Supervision, and Selection

SFT is a complex form of psychotherapy, which requires extensive training to master. *The rigors of working with forensic patients make the need for thorough training of SFT therapists imperative (Guideline 11).* There are as yet no agreed upon international standards for training in SFT. However, at the First International Conference of the International Society for Schema Therapy, Jeffrey Young proposed that Schema Therapists receive a minimum of 5 days of training, followed by 50 hours of supervision (J. Young, personal communication, April 23, 2006). Training for therapists working in

forensic settings should emphasis Schema Mode case conceptualization and treatment methods.

Supervision is essential for therapists in the early stages of their SFT training. Many therapists working in forensic settings have difficulty getting started with SFT, even after they have attended SFT workshops, unless they have the support and guidance of regular supervision sessions. This is not surprising, given the challenges of learning SFT and working with forensic patients with severe personality disorders. In our experience, *regular supervision or peer supervision sessions are necessary to insure the effective delivery of SFT in forensic settings (Guideline 12).* Because SFT is a complex form of therapy, it is best learned after therapists have already acquired some basic psychotherapy skills. *We recommend that therapists have at least 3 years of prior psychotherapy experience before they attempt to master SFT (Guideline 13).* Moreover, *we recommended that competency ratings for therapists become standard practice, particularly in forensic settings in which the therapists' competency may affect patients' recidivism risk (Guideline 14).* Rating therapists' competency can be conceptualized as a "quality control" procedure that assures that SFT is delivered to an acceptably high standard.

Alternative Forms of SFT

SFT was developed as an individual form of verbal psychotherapy. However, alternative forms of SFT have recently been created that hold considerable promise for the forensic field, such as drama, art, movement, music, and group therapy versions of SFT. In some cases, other forms of SFT may be useful as supplements or alternatives to SFT in its original individual, verbal form, especially for patients whose verbal skills are limited. In another promising development, one forensic hospital in The Netherlands, the Rooyse Wissel, has incorporated SFT principles on a system-wide basis. SFT principles and methods have been integrated into each phase of treatment from intake to discharge. Thus, SFT concepts are used as a unifying principle that provides a coherent rationale for the treatment efforts of the entire institution.

CONCLUSION

Our adaptation of SFT for forensic patients and recommendations for clinical practice represent a work in progress. No doubt they will be modified and refined as we gain greater experience in working with this population. A multi-center, randomized clinical trial of SFT with forensic personality disorder patients that we have recently begun in the Netherlands with 7 collaborating institutions should help us further refine these ideas in light of empirical evidence. We hope that the ideas contained in this article will prove helpful to those attempting to improve the effectiveness of treatment for this challenging population.

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