# 12

# Schema Therapy in Forensic Settings

David Bernstein, Marije Keulen-de Vos, Philip Jonkers, Ellen de Jonge and Arnoud Arntz

## Introduction

Forensic patients pose special challenges that are uncommon in general psychiatry. These patients usually have problems with aggression, impulsivity, or anger. Some patients deceive and manipulate to achieve their goals. Many patients are very wary, which makes them difficult to engage in treatment. Patients with personality disorders represent the most prevalent diagnostic group in most forensic settings (Rasmussen, Storsaeter and Levander, 1999; Timmerman and Emmelkamp, 2001; Hildebrand and de Ruiter, 2004; Leue, Borchard and Hoyer, 2004). Cluster B personality disorders (e.g., antisocial, borderline, and narcissistic personality disorder) are especially common. Cluster B patients, and especially highly psychopathic patients, have an increased risk of recidivism (Salekin, Rogers and Sewell, 1996; Hemphill, Hare and Wong, 1998; Rosenfeld, 2003; Jamieson and Taylor, 2004). Many experts are skeptical that psychotherapy can treat these patients, though there is little empirical support for this view (D'Silva, Duggan and McCarthy, 2004). In contrast, Schema Therapy (ST) has a more optimistic perspective on change in severe personality disorders (Young, Klosko and Weishaar, 2003; Rafaeli, Bernstein and Young, 2011), a view that is supported by findings of a recently completed multicenter randomized clinical trial on borderline personality disorder (BDP) outpatients (Giesen-Bloo *et al.*, 2006). Of the patients randomized to receive ST, 50% were judged to have recovered from their BDP pathology and 70% showed clinically significant improvement after three years of therapy and a one-year follow-up (Giesen-Bloo *et al.*, 2006).

These impressive results inspired Bernstein and Arntz to adapt ST for forensic patients with personality disorders (Bernstein, Arntz and de Vos, 2007). This forensic adaptation of ST is currently being tested in a multicenter randomized clinical trial at seven Dutch forensic hospitals in the Netherlands. Our preliminary findings in the

*The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice*, First Edition.
Edited by Michiel van Vreeswijk, Jenny Broersen, Marjon Nadort.
© 2012 John Wiley & Sons, Ltd. Published 2012 by John Wiley & Sons, Ltd.

first cohort of 33 patients to complete two years of treatment are promising: over 80% of the patients randomized to receive ST were approved to begin the process of supervised re-entry into the community – a crucial phase of treatment in the Dutch forensic system – compared to 60% of patients receiving usual forensic treatment (Bernstein, 2009). Although these findings are preliminary – patients must complete three years of treatment and a three-year follow-up, and a much larger sample is being recruited and tested – they suggest that ST may be able to help some of the most challenging forensic patients with personality disorders, a population that is often considered untreatable.

In this chapter we describe the forensic adaptation of ST that is currently being tested in several Dutch forensic psychiatric settings (Bernstein, Arntz and de Vos, 2007). The forensic ST model focuses on personality characteristics that are seen as risk factors for violence and crime. In this model, these risk factors are conceptualized as schema modes (Young *et al.*, 2003) – fluctuating emotional states that, when triggered, increase the probability of aggressive, impulsive, or other antisocial behavior. As schema modes are relatively dissociated from each other, they dominate a person and his thoughts, feelings, and behavior at a given point in time (Young *et al.*, 2003). By reducing the severity of these maladaptive modes and enhancing a patient's Healthy Adult mode, forensic ST aims to achieve real personality change, resulting in a reduced risk of future antisocial behavior.

## Clinical Practice

To understand the psychological motivations behind criminal behavior and to guide forensic ST we expanded Young and colleagues' (2003) the original schema mode model by including five "forensic schema modes": Angry Protector, Bully and Attack, Paranoid Over-Controller, Conning and Manipulative, and Predator Mode (Bernstein *et al.*, 2007). In Angry Protector mode, a patient's hostility, irritability, or sullen withdrawal keeps others at a safe distance. In Bully and Attack mode, the patient uses threats or aggression to intimidate others. In Paranoid Over-Controller mode, the patient is hypervigilant and looks for hidden enemies who want to hurt or humiliate him. In Conning and Manipulative mode, the patient presents a "false self" by lying, cheating, or charming others to achieve a certain goal. In Predator mode, the patient eliminates a threat, rival, or obstacle in a cold, emotionless, and ruthless manner.

By using this expanded mode model, "senseless" crimes can sometimes be explained in terms of a sequence of schema modes.

> John's girlfriend ended their relationship. He became furious and, after getting high on drugs, decided to go to her house to kill her. When he could not find her house, he stopped a female stranger to ask for directions. He then pulled her into his van and raped her. During his crime he switched between apparent concern for his victim and threats and intimidation when she refused to do what he wanted.

Edgar, a patient in a drug treatment program, was accused of selling drugs. He became convinced that another patient had betrayed him. Eventually his suspicions fell on a patient whom he suspected of wanting to take over his "territory." Although there was no solid evidence that the informant was this patient, he decided to teach him a lesson. He grabbed a knife and carved a symbol in the man's cheek to show him (and others) not to "mess with him." He expressed little emotion during the attack, while he made sure to carve the symbol so that everyone could see it.

In John's case, abandonment was the trigger (Vulnerable Child mode). The patient tried to calm himself by getting high on drugs (Detached Self-Soother mode), but when his anger became too great (Angry Child mode), he decided to take revenge. When his desired victim, his girlfriend, could not be found, he chose a victim at random. He played with his victim to demonstrate his power over her (Self-Aggrandizer mode) and used threats to ensure she cooperated with his demands (Bully and Attack mode).

In the second case, the belief that another patient had betrayed him was the trigger. He was convinced that he had found the source of his betrayal, despite the lack of evidence (Paranoid Over-Controller mode). He decided to teach his rival a lesson so that there would no doubt as to who was in charge (Self-Aggrandizer mode). Coldly and efficiently, he eliminated the (perceived) threat to his drug dealing (Predator mode).

In these case examples, which involve highly psychopathic patients, emotional states (schema modes) can trigger each other in a sequence culminating in violence. By treating these modes, ST aims to break this chain.

## Approach

In our experience over the past five years, many forensic patients can benefit from ST, provided that their therapists become familiar and adept at working with the kinds of schema modes that are most common in forensic patients. The basic ST approach remains the same when working with these types of patients as it does when working with personality disorders in general. However, in forensic ST the following issues are stressed.

### The reparenting relationship

The reparenting relationship is the cornerstone of forensic ST, just as it is for ST in general (Young *et al.*, 2003). However, many forensic patients are extremely mistrustful and emotionally detached, which makes them more difficult to engage in treatment. Thus, the therapeutic relationship needs to be built up slowly. The therapist's consistency, availability, openness, and compassion toward the patient are essential in building this trust. The therapist needs to be patient and optimistic, and must not expect big changes too quickly.

## Schemas and modes

Patients with less severe personality disorders can be treated with standard ST, which emphasizes early maladaptive schemas and coping responses. In contrast, for more severe personality disorders, such as those typically seen in forensic patients (e.g., antisocial, narcissistic, and BDP), ST focuses on schema modes. Because patients with severe personality disorders often switch between emotional states, a schema mode approach helps the therapist monitor and intervene with the modes that appear in the "real time" of the therapy session (Young *et al.*, 2003). Experience shows that most forensic patients understand the mode concept and learn to apply it to themselves quite quickly, so long as they are sufficiently intelligent (e.g., IQ > 80). We teach patients to label their modes, but not their schemas, because switching between schema and mode terms can become confusing for the patient. On the other hand, we do incorporate schemas as an adjunct to modes, though not explicitly. For example, when discussing the Vulnerable Child mode, we can talk about "that side of yourself that is afraid of being abandoned" (Abandonment/Instability schema).

## Assessment and case conceptualization

The schema mode case conceptualization is essential in forensic ST because it determines the strategies that a therapist will use to target a patient's schema modes in treatment. The assessment combines different sources of information, including criminal records and observations of the patient's interactions with others (e.g., staff members and patients), as well as other sources traditionally used in ST assessment (e.g., schema and mode inventories, imagery for assessment). The therapist teaches the patient the schema mode model. He presents the patient with a simplified version of his case conceptualization, starting with a small number of modes that are the initial focus of the treatment.

## Protector modes

Most forensic patients have particularly strong Detached Protector, Angry Protector, and/or Detached Self-Soother modes. They may seem emotionally flat or deny having emotions or problems. They can present themselves as hyper-normal by responding in a socially desirable manner or come across as detached, defiant, or uncooperative. They might use drugs, alcohol, or other compulsive behavior for blocking out painful feelings. Behind these protective modes there is usually a pervasive distrust of other people and a fear of their own emotions. This tendency to stay detached is usually reinforced by the institutional setting in which patients learn to adapt by avoiding people and situations that trigger their problematic behavior. These detached modes are often a main focus of the first two years of forensic ST. The therapist uses standard ST techniques such as empathic confrontation, role-play (e.g., two-chair method), and guided imagery, and above all, the slow building of trust through the reparenting relationship, to break through the patient's detachment and gain access to the child modes that are usually hidden underneath.

### Vulnerable Child mode

Some forensic patients can easily experience and admit to inner pain. Others deny such feelings altogether. In our experience, when a patient denies having any feelings, this is due to the Detached Protector mode or other modes that block access to the Vulnerable Child mode. Evidence supporting the assumption that these patients do have a more emotional side is that they often refuse to do imagery exercises or get extremely upset because of the emotions that are released through imagery. Even patients who deny having any feelings will often acknowledge that they don't trust others or that they feel that others try to humiliate them. Thus they make external attributions (Weiner, 1990) where others are seen as the cause of their emotions ("I do not feel humiliated. *You* are trying to humiliate me!") rather than feeling that their emotions are intrinsic to themselves. Discussing with the patient which side of him feels mistrustful can be a first step in accessing the patient's vulnerability. Although we cannot be certain that all forensic patients have a vulnerable side, our experience suggests that even highly detached psychopathic patients may show vulnerable feelings under some circumstances.

How many forensic patients, especially psychopathic ones, are able to experience emotions remains unknown. Research suggests that psychopathic patients often show deficits in the ability to recognize emotions, particular fear and sadness, and that these deficits are tied to low amygdala activation in the brain (Blair, Mitchell and Blair, 2008). However, we have observed many examples where ST has been able to break through the emotional reserve of even highly psychopathic patients to reach the patient's vulnerable side. This suggests that a schema mode model, in which patients switch between detached and more vulnerable emotional states, may capture the emotional reality of many forensic patients better than a trait model that assumes that patients are the same way all the time.

In his first therapy session, Gerry, a forensic patient, told his therapist not to bother exploring his feelings, because he was a psychopath and didn't have any emotions. The patient had a highly traumatic background, having been physically and emotionally abused by his father at a very young age and placed in foster care at the age of four. When asked about these experiences, he said that he "didn't give a damn" about them. Gerry was highly emotionally detached and self-aggrandizing, acting in an aloof, arrogant, and at times intimidating manner. He continued to deny feelings whenever he was asked about them. On one occasion, however, he needed to be hospitalized for a medical emergency. When his girlfriend visited him, he broke down in tears. Later, when his therapist asked him about this episode, he replied that he almost never experienced such feelings, and that the therapist should not expect to witness them again.

Henry, a highly psychopathic patient, had been in ST with a female therapist for about one year when he arrived for a session appearing palpably anxious. His therapist had never before seen him in such a state. Henry had been convicted of rape and sentenced to treatment in a forensic hospital. He rarely showed his feelings and was described by many as a "classic psychopath." In his session, he told his therapist that he had suddenly realized how frightened he was of women. He revealed that he had been impotent in some of his sexual encounters. Thus, for the first time he was able to show his therapist a vulnerable side that had not previously been apparent. This breakthrough signaled the beginning of a new phase of the therapy, in which his vulnerable side could be explored and eventually integrated.

### Impulsive Child mode

Many forensic patients grew up in families where few boundaries were set. These patients are not able to tolerate frustration or comply with rules, because they never learned to do this as a child. Instead, they have a strong Impulsive Child mode that "wants what he wants when he wants it," and behaves without thinking about the consequences.

Helping the patient to accept limits is a crucial part of the therapist's reparenting role. This is complicated by the fact that these patients often experience limits as punitive and arbitrary, and mistrust the intentions of those in authority. This is not surprising, given the inadequate parenting that many have experienced, which often fluctuated unpredictably between being overly permissive and overly punitive or even abusive. Thus, the therapist's providing firm but fair and consistent limits is an important aspect of reparenting – in fact, just as important as providing the nurturance that was also often missing in these patients' childhoods.

Ron, a hospitalized forensic patient, had made a painting that he wanted to hang on the wall of his room. He was so excited by this prospect that he decided to take a hammer and nail from the workshop where he had made the artwork and bring it to his room on the inpatient ward where he lived. When he entered the ward, he encountered a staff member who asked if he had received permission from the ward chief to carry the hammer and nails onto the ward. He said that he had received the ward chief's permission, although he had not. Only later did he acknowledge having fleetingly considered the consequences of his ill-conceived actions, but had decided, "Oh, what the hell!" and gone ahead anyway.

### Angry Child and Angry Protector modes

The ST therapist must learn to distinguish different modes that refer to anger or aggression, such as Angry Child, Angry Protector, Bully and Attack, and Predator modes.

Knowing which mode is present "in the room" at a given moment in time is the key to knowing how to intervene, because different modes call for different interventions. For example, Young *et al.*, (2003) have proposed three steps for dealing with the Angry Child mode: venting the emotion, empathizing with the patient, and reality testing. This strategy works well when the patient expresses his anger openly. Many forensic patients, however, express their anger indirectly, through irritation, sulking, pouting, complaining, withdrawal, and oppositional behavior – in other words, the Angry Protector mode. This behavior is self-defeating because other people are unable to empathize with the patient's feelings and instead feel irritated with or frustrated with the patient. In fact, the Angry Protector mode serves the function of erecting a "wall of anger" that keeps others at a safe distance, where they can't harm the patient. The therapist uses empathic confrontation and other techniques to explore the reasons why patients may feel unable to express their feelings directly, while at the same time emphasizing the self-defeating nature of this behavior. At the same time, in his reparenting role, he encourages the healthy, constructive expression of anger.

## Over-compensatory modes

Over-compensatory modes are the hallmark of patients with antisocial personality disorder, and especially of patients who are highly psychopathic. Our research indicates that a cluster of five schema modes – the Self-Aggrandizer, Bully and Attack, Conning Manipulator, Paranoid Over-Controller, and Predator modes – are highly associated with the interpersonal features of psychopathy (Keulen-de Vos, Bernstein and Arntz, 2010). These five modes are based on an over-compensatory coping style in which the patient "turns the table" on other people and attempts to gain the upper hand. If the patient feels humiliated, he tries to humiliate others (Self-Aggrandizer mode). If he fears that others will hurt or abuse him, he goes on the offensive, bullying and intimidating them (Bully and Attack mode). If he feels that he cannot get his needs met in an open and direct way, he gets what he wants in an indirect way (Conning and Manipulative mode). If he experiences other people as dangerous, he seeks out his enemies before they can attack him (Paranoid Over-Controller). If he sees the world as consisting of victims and predators, he makes a cold, calculating decision to be a predator rather than a victim (Predator mode). Thus, each of these modes reflects a specific kind of coping response involving a tendency to over-compensate for underlying schemas of abuse, deprivation, humiliation, abandonment, and so forth.

In our experience, over-compensatory modes are almost always involved in patients' acts of crime and violence. Although patients often take pains not to show these sides of themselves to treatment providers, they are often expressed in more subtle forms of demeaning, intimidating, controlling, or manipulative behavior directed at the therapist. Moreover, in forensic settings, these sides of the patient may be more evident in patients' encounters with each other, for example, in battles over positions in dominance hierarchies on the ward, or in conflicts with staff members who attempt to set limits. These kinds of interactions are described in the forensic literature as "offense-paralleling behaviors" (Jones, 2004) – behaviors occurring in the forensic setting that parallel the patients' pattern of violent and criminal behaviors. In ST, such offense-paralleling behaviors can be conceptualized in terms of schema modes, particularly modes involving over-compensation. When these modes appear in therapy

sessions or on the ward, they provide an opportunity for the therapist and other staff members to call the patient's attention to them, initiating a process whereby the patient can become aware of these sides of himself, the reasons why they exist, and their destructive and self-defeating consequences.

## Pitfalls and Recommendations

### Self-Aggrandizer mode

Many forensic patients, particularly narcissistic and psychopathic patients, have a Self-Aggrandizer mode. This mode can hinder treatment progress, especially if the patient denigrates the therapist. When the therapist does not respond to the deprecating attitude of the patient, the patient is inclined to see the therapist as weak and to escalate his vilifications. For this reason, the therapist must confront the patient directly and immediately, but without being judgmental. A pitfall is when a therapist over-compensates for his own schemas (e.g., Defectiveness/Shame) and tries to put the patient in his place (Self-Aggrandizer mode), or on the other hand, behaves in a submissive manner (Compliant Surrender mode), which only encourages further denigration from the patient. Instead, the therapist should be firm but compassionate, not afraid to address a patient's arrogant or deprecating behavior, but in a respectful and non-threatening manner.

### Conning and Manipulative mode

Dealing with patients' lies or manipulation is one of the most difficult challenges of working in the forensic field. When a patient cries, for example, it is sometimes difficult to know whether the emotion is sincere or designed to get the therapist's sympathy. In other instances, the patient may ask the therapist for special favors or try to get the therapist on his side in a conflict. Forensic care providers have an understandable and sometimes justified tendency to be cautious about patients' manipulative behavior. Some go too far, however, if they instinctively react mistrustfully toward patients. On the one hand, the ST therapist has to be able to respond to the genuine feelings and needs of a patient (e.g., by providing limited reparenting). On the other hand, he has to confront him with his inauthentic and manipulative

> Dimitri, a patient in a forensic hospital, sued the hospital for alleged malpractice. He had previously been treated in another forensic hospital, which he had also sued, winning a sizable award. His therapist saw Dimitri as an innocent victim of circumstances. However, the therapist may have been missing another side to the story. Dimitri had been twice interviewed for psychopathic tendencies with the Psychopathy Checklist-Revised (PCL-R; Hare, 1991). On the first occasion, he had received only a moderate score, but on the second occasion, he was given a score in the psychopathic range. Such a discrepancy could have raised doubts about the patient's sincerity.

behavior (e.g., through empathic confrontation). In our experience, most therapists are aware when patients are trying to manipulate them and can discern the difference between authentic and inauthentic emotions. However, we have also come across exceptions, particularly in treating highly psychopathic patients.

A high PCL-R score does not necessary mean that the patient cannot be trusted. The schema mode model assumes that patients may switch between modes in which they show genuine emotions and other modes in which they con and manipulate. For this reason, it is essential that therapists who work with forensic patients get regular supervision or peer supervision in which they can receive feedback from colleagues. Making video recordings of therapy sessions, which can be shown to supervisors or colleagues, is an effective way to elicit colleagues' impressions of patients' schema modes. This can help therapists avoid the pitfalls that sometimes occur in working with forensic patients who may lie or manipulate.

## Limit-setting and empathic confrontation

The ST therapist sets limits when a patient's behavior is threatening or insulting, when it undermines the therapy, or is a danger to the patient or others. When the therapist fails to set limits, the behavior of the patient often escalates. ST therapists set limits in a clear, decisive, but non-punitive way. They emphasize the differences between healthy expressions of anger and the patient's threatening or insulting behavior. Most forensic patients calm down quickly when they sense that a therapist is strong enough to set limits in a determined but non-punitive way. If the threatening or dangerous behavior continues, the therapist tells the patient that he will impose consequences, if the patient is unable to respond to limits. When aggressive modes such as Bully and Attack or Predator mode are present in a session, an intervention should follow immediately, either by empathic confrontation or by limit-setting. The choice of the intervention depends on the seriousness of the aggression: the more serious the threats or aggressive behavior, the more likely it is that the therapist will set limits before he can explore the reasons for the presence of this mode. Although less obvious than in cases of overt aggression, limits may also need to be set when schema modes threaten to undermine the therapy.

> In his first session, Eli, a forensic patient, told his therapist that his goal in the therapy was to have the therapist know as little about him by the end of the therapy as at the beginning. He refused to make eye contact with the therapist, and gave only one- or two-word answers to her questions. He stared at the floor, while she patiently tried to introduce new topics that the patient would respond to. After several months in which she grew more and more frustrated and angry, she finally decided to confront Eli about his Angry Protector mode, which was making therapy impossible. She told him that she had reached the end of her patience and would have to stop the therapy unless he could take some risks to open up and share more with her. The intervention worked. Although he was initially taken aback, he agreed to her conditions, which enabled the therapy to move forward.

Many therapists feel uncomfortable about setting limits, because it is a skill that most are not trained in. However, it can be very empowering for them to learn this skill and to see how limit-setting can ultimately help patients to gain greater self-control.

## Experiential techniques

For many forensic patients, traditional "talking therapies" are insufficient to break through their emotional detachment. The patient may talk in a fluent but unemotional and superficial way about his problems, spend his time complaining about the forensic institution and the unfair way that he is being treated, or avoid discussing himself and his feelings altogether. In such circumstances, the therapist may feel that the therapy is going nowhere and respond to this lack of progress by becoming detached or bored himself, or by getting angry at the patient. For this reason, experiential techniques play a vital role in ST with forensic patients. Experiential techniques, such as guided imagery and role-play, are used in ST to access and reprocess patients' emotions. These techniques are particularly effective in bypassing patients' detached modes and accessing more vulnerable emotions (Holmes and Mathews, 2005).

Although some forensic patients participate quite readily in experiential exercises, others are reluctant to do them. This is understandable, given that many of these patients are quite frightened of their own emotions, which they often associate with traumatic experiences from childhood or with their own proneness to anger and violence. When forensic patients are reluctant to do experiential exercises, it is important to explore the reasons for their hesitancy and to gently persist in getting them to try them. Some patients who initially refuse to do experiential exercises will agree to do them later in the therapy, after sufficient trust in the therapist has developed. Other patients will agree to do these exercises if their purpose is explained sufficiently or when procedures are introduced that make them less threatening (e.g., beginning imagery with an image of a safe place; allowing patients to do imagery with their eyes open while focusing on a fixed point, rather than closing their eyes; letting the patient signal for a "time out" if the exercise is becoming too overwhelming). In our experience, many if not most forensic patients will eventually engage in experiential exercises, often with beneficial effects.

> Han, a psychopathic forensic patient, had developed a good relationship with his ST therapist. However, after more than a year in therapy, he still refused to try experiential techniques. Eventually, his therapist confronted him, saying that she felt that the therapy could go no further unless he was willing to give these techniques a try. After she explored the reasons for his reluctance, and again explained the purpose of the techniques, Han agreed to try guided imagery. The image that he produced was one where he was beaten as a teenager by his sadistic father. Further, at a moment when his father was off guard, Han had caught him by surprise and savagely beaten him. This image represented a turning point in the therapy, since it vividly put the patient in touch with his mistrust and fear of abuse and the over-compensatory way in which he had learned to take the role of aggressor to protect himself from victimization.

## Motivating and engaging forensic patients

Forensic patients vary in their motivation for treatment. Some patients are quite willing or even eager to engage in the therapeutic process, while others are reluctant or refuse. The patient's active participation in treatment is usually considered a prerequisite for success. However, when the patient refuses to recognize that he has a problem, appears not to be suffering from his problems or to have a desire to change, or fails to engage in the basic tasks of therapy, such as forming a bond with his therapist, agreeing on the goals of treatment, or self-disclosing, we often describe him as "unmotivated," "non-compliant," or "resistant." These patients are understandably highly frustrating for the professionals who work with them. In many cases, such patients are denied further attempts at treatment, creating a self-fulfilling prophesy in which treatment is withheld from the patients who need it the most. Recent research, however, suggests that treatment motivation is a dynamic rather than a static concept (Drieschner, Lammers and van der Staak, 2004). Patients' willingness or ability to engage in therapy may change over time. Motivational interviewing methods, for example, have been shown to enhance the treatment motivation of patients with addictive disorders, as well as patients in forensic settings (McMurran, 2009).

ST is not predicated on patients being ready or motivated for psychotherapy. Instead, it views patients' motivation in terms of the schema modes that are active at any one time. Thus, patients' motivational levels fluctuate with their emotional states, which can be triggered by a number of internal and external factors, including the therapy and the forensic setting itself. Rather than being "unmotivated" or "resistant," patients are viewed in terms of the sides of themselves ("schema modes") that present obstacles to treatment. For example, the Detached Protector mode says, in effect, "Don't ask me about my feelings – I don't have any!" The Self-Aggrandizer mode says, "I don't have a problem – you do!" The Angry Protector mode says, "I can't trust you – keep away from me!" The goal is to work with these sides in order to flip or switch patients into modes that are more therapeutically productive, such as the Vulnerable Child mode, in which patients are directly in touch with their feelings, and the Healthy Adult mode, in which patients can reflect on themselves and their situation in a balanced and objective way. The therapist works with the full range of ST techniques in order to enhance the patient's motivation, although reparenting undoubtedly plays the most important role in overcoming the patient's mistrust and beginning to reach his vulnerable side. Enhancing the patient's motivation and building the therapeutic relationship via reparenting is usually the central focus in ST with forensic patients in the first year of therapy.

> Paul, a forensic patient with a high psychopathy score and a history of aggressive, impulsive, and antisocial behavior, had made no progress during four years of treatment at a previous forensic hospital. At his new hospital, his behavior alternated between friendly and cooperative and periods in which he became angry and refused to participate in treatment. At the beginning of ST, he missed many sessions, but seemed to enjoy the sessions he did attend. He was angry

with the clinic and the Ministry of Justice, and sometimes threatened to terminate his treatment, saying, "Just lock me up for life and throw away the key!" At the same time, he seemed to respond positively to the therapist's attention and grew calmer when the therapist asked him how his Healthy Adult side would respond to these statements. Nevertheless, he continued to be provocative in his behavior outside of the sessions and caused a number of incidents, receiving numerous sanctions.

After six months of ST, the hospital requested that his forensic treatment be terminated and that he be sent to a "long-stay" facility, where he would be detained indefinitely. This shocked Paul and represented a turning point in his treatment. Although the rest of his treatment activities were stopped at this point, he requested that he be allowed to continue with ST and increased his frequency of sessions from once to twice a week. He began to see that his difficulties with the hospital stemmed from his own impulsive and aggressive behavior (Impulsive Child and Angry Protector modes, respectively). Using the two-chair technique, an experiential method in which different sides of the patient are asked to sit in different chairs and dialogue with each other, the therapist explored with him the advantages and disadvantages of these modes. The patient became better able to view things from his Healthy Adult side and started to experience remorse for his actions. When Paul expressed frustration with his treatment, or asked to end a session early because "there was no point in talking," his therapist used empathic confrontation to help him see the sides of him that were blocking progress. The therapist was then able to help Paul articulate goals for the therapy that served to enhance his motivation (e.g., learning to be less impulsive so that he would receive fewer sanctions; being calmer during his daughter's visits). Paul agreed to go on medication, which he had previously refused, to help him stay calm.

At this point, his Protector modes seemed to diminish and the therapist was able to make more contact with his vulnerable, lonely, and anxious sides. The therapist introduced imagery exercises, where Paul was able to re-experience painful events from his childhood, with the therapist "stepping into" the images to provide reparenting directly to the Vulnerable Child. In this way, the therapist was able to give "little Paul," in imagery, some of the love and attention that he lacked as a child and protect him from the abusive father who had terrorized him. Paul seemed notably relieved after these imagery exercises, and his behavior in the hospital became calmer and more cooperative. After 18 months, the hospital withdrew its application for "long-stay." Although Paul's further treatment had its ups and downs, as is the case for many forensic patients, he continued to make progress. After two years of ST, the clinic requested that Paul begin the resocialization process, which involves granting the patient leave to go outside the hospital with progressively less stringent levels of supervision, with the goal of reintegrating him into the community. This indicated that the hospital no longer considered him at high risk for recidivism. In his many years of forensic treatment, he had never before reached this point, at which he could see a future outside of the hospital.

## The Future

The adapted mode approach presented in this chapter is a work in progress. A multi-center randomized clinical trial on this forensic adaptation of ST is currently being conducted in several Dutch forensic psychiatric hospitals (see Part VI, Chapter 1). The results of this study will provide crucial information about the effectiveness of ST in reducing the personality disorder symptoms and recidivism risk of forensic patients. Our experiences so far and the preliminary results of this study (see above) suggest that ST is a promising approach for many forensic patients with personality disorders.

## References


Bernstein, D. (2009) Effectiveness of schema-focused therapy for forensic patients with Cluster B personality disorders. Paper presented at the 9th Annual Congress of the International Association of Forensic Mental Health Services, Edinburgh, Scotland.

Bernstein, D., Arntz, A. and de Vos, M. (2007) Schema-focused therapy in forensic settings: theoretical model and recommendations for best clinical practice. *International Journal of Forensic Mental Health*, *6*, 169–183.

Blair, J., Mitchell, D. and Blair, K. (2008) *The Psychopath: Emotion and the Brain*. Oxford: Blackwell.

D'Silva, K., Duggan, C. and McCarthy, L. (2004) Does treatment really make psychopaths worse? A review of the evidence. *Journal of Personality Disorders*, *18*, 163–177.

Drieschner, K., Lammers, S. and Staak, D. van der (2004) Treatment motivation: an attempt for clarification of an ambiguous concept. *Clinical Psychology Review*, *23*, 1115–1137.

Giesen-Bloo, J., van Dyck, R., Spinhoven, P. *et al.* (2006) Outpatient psychotherapy for borderline personality disorder: a randomized clinical trial of schema-focused therapy versus transference-focused psychotherapy. *Archives of General Psychiatry*, *63*, 649–658.

Hare, R.D. (1991) *Manual for the Hare Psychopathy Checklist–Revised*. Toronto: Multi-Health Systems.

Hemphill, J., Hare, R. and Wong, S. (1998) Psychopathy and recidivism: a review. *Legal Criminology Psychology*, *3*, 141–172.

Hildebrand, M., and De Ruiter, C. (2004) PCL-R psychopathy and its relation to DSM-IV Axis I and II disorders in a sample of male forensic psychiatric patients in the Netherlands. *International Journal of Law and Psychiatry*, *27*, 233–248.

Holmes, E. and Mathews, A. (2005) Mental imagery and emotion: a special relationship? *Emotion*, *5*, 489–497.

Jamieson, L. and Taylor, P. (2004) A re-conviction study of special (high security) hospital patients. *British Journal of Criminology*, *44*, 783–802.

Jones, L. (2004) Offence paralleling behavior (OPB) as a framework for assessment and interventions with offenders. *Applying Psychology to Forensic Practice* (eds A. Needs and G. Towl). Malden, MA: Blackwell.

Keulen-de Vos, M., Bernstein, D. and Arntz, A. (2010) Assessing schema modes in forensic patients. Paper presented at the bi-annual meeting of the International Society for Schema Therapy, Berlin, July.

Leue, A., Borchard, B. and Hoyer, J. (2004) Mental disorders in a forensic sample of sexual offenders. *European Psychiatry*, *19*, 123–130.

McMurran, M. (2009) Motivational interviewing with offenders: a systematic review. *Legal and Criminological Psychology*, *14*, 83–100.

Rafaeli, E., Bernstein, D. and Young, J. (2011) *Schema Therapy: Distinctive Features*. London: Routledge.

Rasmussen, K., Storsaeter, O. and Levander, S. (1999) Personality disorders, psychopathy, and crime in a Norwegian prison population. *International Journal of Law and Psychiatry*, *22*, 91–97.

Rosenfeld, B. (2003) Recidivism in stalking and obsessional harassment. *Law and Human Behavior*, *27*, 251–265.

Salekin, R., Rogers, R. and Sewell, K. (1996) A review and meta-analysis of the Psychopathy Checklist and Psychopathy Checklist–Revised: predictive validity of dangerousness. *Clinical Psychology*, *3*, 203–215.

Timmerman, I.G. and Emmelkamp, P.M. (2001) The prevalence and comorbidity of Axis I and Axis II pathology in a group of forensic patients. *International Journal of Offender Therapy and Comparative Criminology*, *42*, 198–213.

Weiner, B. (1990) Attribution in personality psychology, in *Handbook of Personality Theory and Research* (ed. L.A. Pervin). New York: Guilford Press, pp. 465–484.

Young, J.E., Klosko, J. and Weishaar, M. (2003) *Schema Therapy: a Practitioner's Guide*. New York: Guilford Press.