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Short-term group schema cognitive-behavioral therapy for young adults with personality disorders and personality disorder features: Associations with changes in symptomatic distress, schemas, schema modes and coping styles

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ABSTRACT

The aim of this pilot study was to document the effects of a group schema cognitive-behavioral therapy intervention (SCBT-g; van Vreeswijk & Broersen, 2006) on global symptomatic distress in young adults with personality disorders or personality disorder features. We also sought to determine the stability of maladaptive schemas, schema modes, and coping responses throughout treatment as well as relations among these variables with improvement in symptomatic distress during treatment. Twenty-six young adults (mean age 22.5 years; range: 18–29 years) with a primary diagnosis of a DSM-IV Cluster-B or Cluster-C personality disorder or with personality disorder features participated in the 20-session SCBT-g protocol. Global symptomatic distress decreased substantially from pre-treatment to post-treatment (d = 0.81). Maladaptive schemas, schema modes and dysfunctional coping responses decreased with medium to large effect sizes (d's = 0.56 and 0.98, respectively), however decrease in maladaptive schemas was not significant after controlling for symptomatic distress. Adaptive schema modes increased slightly (d = 0.40) throughout treatment. Baseline levels of maladaptive schemas predicted symptomatic distress concurrently and at mid-treatment but not at post-treatment. Our findings provide preliminary evidence that SCBT-g might be an effective treatment for young adults with personality disorders or personality disorder features in terms of improvements in global symptomatic distress and underlying vulnerability.

Introduction

Personality disorders usually have their onset in adolescence or early adulthood (American Psychiatric Association, 2005). Adolescents or young adults with personality disorder symptoms suffer from increased functional impairments later in life (Skodol, Johnson, Cohen, Sneed, & Crawford, 2007) and are at an elevated risk of suicidality and development of axis-I disorders in adulthood (Johnson et al., 1999).

Despite the importance of effective treatments for adolescents and young adults with personality disorders, there is a lack of research on the effectiveness of psychotherapeutic interventions for this patient group. Schema Therapy (ST) is a relatively new integrative treatment approach to chronic axis-I and axis-II disorders (Young, Klosko, & Weishaar, 2003). According to this model, stable and enduring Early Maladaptive Schemas (EMS) are at the core of chronic axis-I and axis-II disorders (Young et al., 2003). The ultimate goal of ST is to decrease the impact of EMS and to replace negative coping responses and schema modes with more healthy ones.

A number of studies support the effectiveness of ST for personality disorders (Bamelis, Evers, Spinhoven, & Arntz, 2013; Farrell, Shaw, & Webber, 2009; Giesen-Bloo et al., 2006; Nadort et al., 2009; Nordahl & Nysaeter, 2005) and studies in other patient groups are underway (Bernstein, Arntz, & de Vos, 2007; Bernstein et al., 2012; Renner, Arntz, Leeuw, & Huibers, 2013). In a naturalistic study of 63 outpatients with various axis-I disorders and/or personality problems it has been shown that even a short-

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term group schema cognitive behavioral intervention (SCBT-g; van Vreeswijk & Broersen, 2006) is associated with improvements in overall symptomatology, EMS and schema modes (van Vreeswijk, Spinhoven, Eurelings-Bontekoe, & Broersen, 2012). Providing ST in group format can be a cost-effective alternative to the individual format and has several therapeutic advantages (Farrell et al., 2009).

The group ST model of Farrell and Shaw (1990) should be distinguished from the SCBT-g protocol described by van Vreeswijk and Broersen (2006). While the former places special emphasis on experiential techniques and group processes, the latter is more structured, protocolized and places a greater emphasis on psychoeducation and cognitive techniques. The model of Farrell and Shaw (1990) has a greater focus on schema modes whereas SCBT-g has a greater focus on EMS. The shorter and less intense SCBT-g protocol (van Vreeswijk & Broersen, 2006) might be especially suitable for young adults because core underlying schemas (EMS) of young adults might not be completely formed yet and are therefore less rigid and more amenable to change.

The aim of the current study was to test the effects of SCBT-g on changes in global symptomatic distress in young adults with Cluster-B and Cluster-C personality disorders or with personality disorder features in an open trial. We also aimed to determine the stability of EMS, coping responses and schema modes throughout treatment as well as relations among these variables with improvements in symptomatic distress during treatment.

Methods

Participants

Twenty-eight outpatients recruited from a specialized secondary care facility in the Netherlands (PSY-Q, Roermond) participated in an open trial of SCBT-g (van Vreeswijk & Broersen, 2006). Of the 28 patients who started with SCBT-g, two dropped-out before the mid-treatment assessment (one had borderline personality disorder and one had subthreshold cluster-c and borderline symptoms). Therefore, the analyses are based on the remaining 26 participants who completed treatment and all assessments. The study was approved by the local medical ethics committee and all patients enrolled provided informed consent. The inclusion criteria were a primary diagnosis of a Diagnostic and Statistical Manual for Mental Disorders, fourth edition (DSM-IV; American Psychiatric Association, 2005) axis-II disorder or meeting subthreshold criteria of a DSM-IV axis-II disorder as assessed by the Structured Clinical Inventory for DSM-IV (SCID-II; First, Spitzer, Gibbon, & Williams, 1994); an additional inclusion criteria was an age range between 18 and 29 years. Patients were excluded if they had general group therapy contraindications (e.g. hearing impairments), had suicidal tendencies, self-injury or bursts of aggression.

The average age of the sample entering the study was 22.5 years (range: 18–29 years); 17 were female; 20 lived with their parents, 5 lived independently and one patient lived with a partner. Of the overall sample ten patients did not meet full criteria of a personality disorder, six had avoidant personality disorder, five had borderline personality disorder, three had dependent personality disorder, one had narcissistic personality disorder and one had obsessive compulsive personality disorder. The most common co-morbid axis-I disorders were mood disorders ($n = 10$) and anxiety disorders ($n = 7$).

Procedure

Short-term group schema cognitive-behavioral therapy

The SCBT-g protocol (van Vreeswijk & Broersen, 2006) consisted of 18 weekly sessions plus two booster sessions each lasting 90 min. This highly structured protocol has a special emphasis on the cognitive and behavioral methods and techniques of ST although ST specific techniques such as chair work, limited reparenting and empathic confrontation are also employed. In general the group intervention can be divided into three phases. The first phase consists of three sessions of psychoeducation; the second consists of seven sessions in which mainly cognitive techniques are used; the third phase lasts seven sessions and is primarily focused on identifying schema triggering events and prevention of schema triggering in the future. In contrast to individual ST (Young et al., 2003) SCBT-g has a stronger focus on the present, is more structured and protocolized and places greater emphasis on cognitive techniques and EMS (van Vreeswijk & Broersen, 2006). A more detailed description of the SCBT-g protocol can be found elsewhere (Broersen & Van Vreeswijk, 2012).

In addition to the group intervention patients in the current study were allowed to consult a health care professional once in three weeks for 30 min for social, financial, work or school related problems. In the current study, each of the four groups consisted of six to eight patients. Group therapy was conducted by one of two certified schema therapists. Both therapists had approximately eight years of experience with ST and both were trained in ST techniques during a four-day workshop.

Assessments

Axis-I and axis-II disorders were assessed by two independent psychologists prior to entering the study as part of the routine diagnostic procedure at the clinic using the SCID-I and SCID-II interview. Moreover, patients in this study completed a set of self-report questionnaires before the first group session (pre-treatment), three months into therapy (mid-treatment), and after the second booster session (post-treatment).

Symptom Checklist-90

The Symptom Checklist-90 (SCL-90; Derogatis, 1977) is a 90-item self-report questionnaire that measures general symptomatic distress by averaging all scores. The current study used the Dutch version of the SCL-90 which has been shown to have good psychometric properties (Arrindell & Ettema, 1986). In the present study, internal consistency (coefficient alpha) of the overall scale was 0.98 at pre-treatment.

Schema questionnaire – short form

The Schema Questionnaire (SQ) short form is a 75-item self-report instrument assessing 15 early maladaptive schemas (Young, 1998) derived from the original 205-item version (Young & Brown, 1994). Each item is phrased as a negative core belief regarding oneself or ones relation to others and rated along a 6-point scale. Satisfactory psychometric properties have been reported for the SQ (Waller, Meyer, & Ohanian, 2001). The current study used the Dutch version of the SQ short form (Rijkeboer, 2008). The internal consistency (coefficient alpha) of the overall scale in the current study was 0.96 at pre-treatment.

Schema mode inventory

The schema mode inventory version 1.1 (Young et al., 2007) is a 124-item self-report questionnaire designed to assess 14 schema modes. The SMI has been shown to possess adequate psychometric properties (Lobbestael, van Vreeswijk, Spinhoven, Schouten, & Arntz, 2010). Schema modes can be divided into four categories: child modes, dysfunctional coping modes, dysfunctional parent modes, and the healthy adult mode (Young et al., 2003). In the current study we categorized modes into two categories: adaptive schema modes (healthy adult and happy child) and maladaptive schema modes (all other modes) in order to be able to determine