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Schema Therapy in Adolescents

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Schema Therapy (ST) was developed for adult patients, but is also used in the treatment of adolescents (16–23 years old) who develop personality problems. To date, hardly any literature exists concerning ST and adolescents. Searching for the terms "schema-focused therapy and adolescent" in several databases (e.g., Psychinfo and Pubmed, end-2007) resulted in six references, of which four were about family-focused psychotherapy, one was a book review, and one a study into cognitive schemas. In the only treatment study about ST published so far (Giesen-Bloo *et al.*, 2006), patients aged 18 years and older participated, but there was no distinction made between adolescents within the population. Young (2005) provided a case description of a 20-year-old woman with borderline personality disorder and a post-traumatic stress disorder, yet didn't provide guidelines about specific age.

In the Netherlands, there is an interest in this type of treatment for adolescents, but it is little used in practice. An email survey of a limited number of therapists, administered by the authors in the fall of 2007, demonstrated that lack of knowledge about and experience in ST within this target group holds back many therapists from using this type of treatment.

In Practice

There are some points of interest concerning the treatment of adolescents regardless of the nature of the treatment. These result from the developmental phase in which the youngster is. Learning how to deal with autonomy vs. dependency and with his own often strong emotions and those of others are the points of attention. Adolescents have to leave the parental home and establish their own identity. Furthermore, patients who qualify for ST often have a rather tempestuous life with frequent conflicts and problems at school or at work. Their impulsiveness can be expressed in, for instance, excessive substance abuse and parasuicidal behavior.

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Soraya is a 20-year-old woman of Syrian descent. She refers herself for the second time because of her outbursts of anger in intimate relationships. The first treatment ended after she didn't show up several times and finally broke off contact completely. In the evaluation letter, the therapist left the door open. A year later, Soraya got in contact with the therapist again. She experiences a lot of stress in her relationship with her boyfriend. She thinks he will leave her for a Dutch woman. After the reassessment, it appears that she is pregnant. Because it is inappropriate to be pregnant while not being married in her culture, her family puts pressure on her to marry him. Soraya reacts with aggressive outbursts directed at her boyfriend. Nevertheless, she decides to continue her relationship with him.

Approach

Especially at the beginning of treatment there are more hurdles to overcome than is the case with adults. After years of misery, adults mostly have a better understanding that something needs to change. In adolescents, this understanding is variable. They often report that it's not that bad. Their motivation for treatment is easily subverted because they normally suffer less from explicit or long-term dysfunctional behavior as compared to adult patients. The positive side of this picture is that, in general, their life is less wasted in terms of unfinished education, jobs, and relationships, and they still have many opportunities to develop in a positive way.

More limited reparenting from the therapist is required because of the attitude and behavior of the youngster. Furthermore, the therapist must realize that all sorts of traumatic experiences of varying intensity are still fresh in the adolescent's memory and that certain interactions may be very recent (e.g., in contact with parents).

Assessment

Patients at this age often enter treatment on their own initiative for the first time. According to the principle of stepped care but also in order to meet the wishes of the patient, who normally (still) has little motivation to enter long-term treatment, the treatment will, in principle, be short-term. If this treatment is not successful and problems are more related to impulsivity and an inability to cope with emotions, a schema-focused approach can be tried as the next step. As far as we know, in the Netherlands, ST in adolescents is especially used in forensic settings, because a binding agreement in this age group is usually required in order to complete this long-term and intensive treatment successfully.

Motivation

Motivating occurs, as with adults, throughout treatment. Garcia and Weisz (2002) note that the parents of the youth are mentioned as the main factor for dropping

Soraya is offered ST after she ended previous behavior therapy that didn't yield any results. It seems she acts in a schema-affirmative way. The aim of the treatment is that she will start to recognize her own schemas (including Abandonment/Instability) and the way in which these schemas dictate her behavior. Following this, she has to learn to react differently in situations that activate her schemas (e.g., by discussing her anxieties with her partner).

out of the therapeutic alliance. Of course, this doesn't mean that youngsters concur with this. Unfortunately, detailed research here is missing. However Spinhoven, Giesen-Bloo, van Dyck, Kooiman, and Arntz (2005), who studied borderline patients who attended ST, showed that a negative evaluation of the therapeutic alliance (by patient and therapist) was prognostic of dropout. From the outset, there has to be a focus on creating a good, strong therapeutic alliance between the adolescent and the therapist, for example, by continuously asking about the surroundings the adolescent lives in and about the persons and activities that are important in their life.

Diagnostic and case conceptualization

The best thing would be to complete the schema inventories with the therapist during the case conceptualization. Adolescents are often reluctant to do that, or are less conscientious when they do it at home. They would rather avoid confronting their problems – a behavior in which you see the Detached Protector mode again. They will also change their mind about their parents, for example, quite often.
In general, most modes are present in young people, but they haven't yet crystallized. Throughout the day many things are going on, and modes move along in these events. This also has a positive side: modes in adolescents are usually less rigid than they are in adults and therefore easier to tackle within the treatment. An important request for help by adolescents is regarding self-control of anger and aggression. You can often see what can best be described as the Angry Protector mode in them (Bernstein, Arntz and de Vos, 2007).

The role of the parents

One of the biggest differences compared to the treatment of adults is that the therapist often has to deal with the parent(s) right away. Many patients are still living at home. Therefore, it is important to ascertain how the therapist can reach the patient without creating complicated situations with the patient's parents at the beginning of the treatment. During the diagnostic stage it is also important to make clear what role the parents play in the life of the adolescent, and how they can be available for him in a positive manner. Following this, the therapist will discuss with the patient how his parents can be involved in the treatment. Depending on the goal of the conversations and the stage of treatment, this can be done with the parents alone or with the parents and the youngster together. The content of the conversations with

In the case conceptualization, Soraya reported that her parents often let her down as a child because they had important political careers. Later, she challenged negative comments about her parents. Twice, she asked the therapist to talk to her parents alone to explain to them about the origin of her anger and her fear of abandonment. The therapist suggested doing this together as soon as Soraya felt she was ready. Later, Soraya didn't feel the need to arrange such a conversation; she told her parents about her schemas herself.

the parents will be discussed in detail with the adolescent beforehand. The therapist must explain why it is important to discuss certain subjects with the parents, but the patient will take the final decision about what will be discussed. Furthermore, the therapist and patient will agree on how the patient can show that he doesn't want to continue talking about a certain subject.

Appointments and Absences

It is difficult for adolescents to attend therapy twice a week. This is partly because of their ambivalence, but also because they get deeply involved in their daily activities, which may make them forget the appointment or mean that it is not important for them. Therefore, it is important to negotiate the appointments on a regular basis. Care for the patient has priority with regard to this: absence stands in the way of the help that a therapist can and wants to offer. The youngster will be addressed as a Healthy Adult, who has to learn to take care of himself appropriately, as far as possible.

Imagery Exercises

Most adolescents perceive imagery exercises – and to a lesser degree chair work – as "weird" and "stupid." The therapist has to make time for this, without delaying or skipping the exercises. It helps to start the exercise without much explanation and to accept that they won't close their eyes. It is important that the adolescent does not look at the therapist during the imagery exercise; if they do, the imagery will not get enough space. The therapist can turn aside, or ask the patient to focus on a fixed spot (e.g., a table).

Pitfalls and Tips

As mentioned above, adolescents often miss their therapy sessions. A potential pitfall for the therapist is that he will take up the position of the Demanding Parent and will make high demands. It is helpful when the therapist realizes that their behavior

Soraya stubbornly resists the imagery exercises. She refuses to close her eyes to go to her safe place. When she finally closes them briefly, she immediately and emphatically says that "nothing has happened." She is convinced that imagery will "definitely not work for her" and she often laughs and compares imagery exercises disparagingly with hypnosis. She does like the chair work techniques; she can move and walk around.

belongs to the developmental stage. Within treatment, this means discussing the absence, but accepting it and keeping the door open. It is important to keep the meetings formal and to discuss the consequences for the patient himself. Only if this doesn't have the desired effect will the therapist discuss the consequences for the therapeutic alliance: absence makes it more complicated for the therapist to remain involved with the patient. Therefore, there is a risk that the youngster will start to see the therapist as (one of) his parents and will withdraw into one of his protective modes, or he will stay away. Empathic confrontations will easily be interpreted as mothering – especially in the early stages of treatment – and this will lead to absence.

Another potential pitfall is that the therapist tries to be a better parent, especially with adolescents who have been emotionally deprived by their own parents. The way the therapist deals with this doesn't differ from the way adults are treated. Its helps to be aware of this pitfall and staying alert to situations that provoke it.

Furthermore, the therapist has to distinguish between maladaptive schemas and normal adolescent behavior. Most adolescents struggle with the theme of autonomy. When a therapist too quickly sees their attempts at independence as over-compensation for the Dependency/Incompetence schema, the youngster may easily become irritated.

When making an inventory of the problems and case conceptualization several pitfalls can be encountered. The youngster can get into a loyalty conflict by being forced to talk "badly" about his parents while he is in daily contact with them, is dependent on them, and struggles with ambivalent feelings toward them. The emphasis then has to shift so that the patient can "de-accuse" the parents. The therapist discusses the idea that although the parents have played a strong role in the origin of the schemas, it was not their intention to harm their child. They are often struggling with their own problems and pitfalls. This "de-accusing" is a delicate process. On the one hand, the youngster can feel misunderstood and detaches himself from the therapist; on the other, he can start feeling guilty about his parents. The Punitive and Demanding Parent mode can then obstruct progress. In the beginning, this can be practically solved by naming the "strong voice" entirely or partly as part of the adolescent himself, instead of placing it completely "on the outside," determined by the parents.

When the breakthrough of the negative patterns between parents and youngsters is chosen as an explicit aim of treatment, a family or systematic treatment may be necessary – for example, Functional Family Therapy (FFT; Alexander and Sexton, 2002) or Multidimensional Family Therapy (MDFT; Liddle *et al.*, 2001). A treatment such as Multisystemic Therapy (MST; Henggeler, Schoenwald, Borduin,

Rowland and Cunningham, 1998) seems less useful for this group because this treatment strongly focuses on repairing the hierarchy between the parents and youngster.

The Future

Considering the specific points outlined above, development of knowledge regarding this group is required. In this way, it may be possible that group ST can be offered to this age range. In this stage of development, one is more sensitive to the influences of one's peers and solidarity and identification with other adolescents can increase the commitment to the treatment and decrease possible absence. As a continuation of the development of protocols for ST group treatment in adults, the time seems right for the development of a specific version for adolescents.

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