4

Introduction to Group Schema Therapy

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In Part IV some of the Chapters describe a number of different approaches to using Schema Therapy (ST) in a group, with different patient populations, in a range of settings (outpatient, inpatient, day treatment) in the US, the Netherlands, and Germany. ST in groups is described by Young (2010) as the "third phase in the development of ST" and as having great promise. Using ST in a group format is not a particularly new development (Farrell and Shaw, 1994; Young and Pijnakker, 1999; van Vreeswijk and Broersen, 2006; Muste, Weertman and Claassen, 2009), however the publication of studies to evaluate the group models described here is more recent. Open-trial pilots have demonstrated effectiveness (Andrea, 2008; Reiss, Lieb, Arntz, Shaw and Farrell, submitted; van Vreeswijk, Spinhoven, Broersen and Eurelings-Bontekoe, unpublished), however, some of the results have limited availability. One randomized controlled trial (RCT) ($N = 32$) of group ST (GST) (summarized in Farrell and Shaw, 1994) for patients with borderline personality disorder (BPD) demonstrated the group model's effectiveness in reducing BPD symptoms, global psychiatric symptoms, and improved function with very large effect sizes (mean = 2.4) (Farrell, Shaw and Webber, 2009). GST is currently being evaluated in a large multi-site RCT ($N = 448$) in four countries (Arntz and Farrell, 2010) in which two years of a primarily GST condition are compared to a balanced GST and individual ST (IST) condition, with a treatment as usual (TAU) control.

Farrell, Shaw, and Reiss describe GST, which was developed as a comprehensive treatment for patients with BPD. This model has been tested as described above and demonstrated effectiveness in both outpatient and inpatient settings. GST was developed and refined by Farrell and Shaw over the last 25 years and parallels the development of ST by Young (1990; Young *et al.*, 2003) and Arntz (2004; Arntz and van Genderen, 2009). The GST model is theoretically and conceptually consistent with ST. The major differences between the two lie in the strategic adaptation of standard ST interventions such as imagery change work and mode role-plays to actively include the entire group. In this model two equal co-therapists are seen as

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necessary in order to maintain the attachment with patients that is a core component of ST. Unlike interpersonal or process-oriented groups, the therapist role is an active and directive one, based on the developmental level and needs of the group. Patients with BPD are primarily in child modes in the early stages of treatment, so active "parents" are needed. A major difference between the GST model here and cognitive therapy and skills groups (e.g., dialectical behavior therapy) is that the therapeutic factors of groups (summarized in Yalom, 1995) are harnessed strategically to catalyze and augment the active ingredients of ST (i.e., limited reparenting, experiential and cognitive change work, and behavioral pattern-breaking). The full integration of experiential and cognitive work in the same GST session differentiates it from the models presented in the other chapters. GST is the group ST model being tested in the international RCT led by Arntz and Farrell (2010).

Muste describes the use of a group format in a day hospital and inpatient setting. He emphasizes the need for safety and transparency, with attention paid to the therapeutic climate of the group. This group program divides sessions into a cognitive component and a less structured component. Muste's group is described as a "work group" in which schemas and modes that impair the group process are identified and worked with. In this model group, individual and even family sessions are combined according to a patient's needs and what he describes as their "ego strength." Muste thinks that aspects of DBT, Acceptance and Commitment Therapy and mindfulness can be used in group ST. This is a controversial opinion in the ST community because of the possible conflict of these models with the limited reparenting therapist style crucial to ST.

Van Vreeswijk and Broersen present a short-term group program SCBT-g, which was developed for a mixed patient group with Cluster B and C personality disorders. SCBT-g has a published workbook and protocol (in Dutch). This model focuses primarily on the cognitive and behavioral techniques of ST and is described as sharing aspects of both the "classic behavioral" group therapy and interpersonal group therapy. SCBT-g, like GST, considers the different phases that a group passes through and their impact on which ST interventions are chosen in a session. The authors stress the importance of not sticking so rigidly to the protocol that the group therapeutic process and the emotional process of the patients are not attended to. Preliminary (unpublished) outcome data support the efficacy of this model (van Vreeswijk *et al.*, unpublished).

Aalders and van Dijk describe integrating ST with a psychodynamic group model. This model is described as contraindicated for patients who are currently suicidal or self-injuring, aggressive or abusing drugs, and they limit the number of narcissistic, BPD, and Cluster C patients. Consequently, this model is more restrictive of patient population treated than the others in these chapters. They divide their sessions into an hour of ST techniques followed by an unstructured hour, which they describe as focusing on "psychodynamics." The first hour includes standard ST interventions such as imagery rescripting in which the focus is on an individual with the group observing or involved, role-play, and diary cards. The second hour has no agenda and patients may introduce any topic. As with traditional interpersonal process groups, members are encouraged to react to each other freely. In contrast, the Farrell-Shaw GST prohibits using this group model for BPD patients since it is an approach designed to engender conflict and high emotions.

As these chapters demonstrate, the therapy group is an effective modality for ST, which can be particularly effective for remediating the interpersonal effects of schema driven and mode behavior of a variety of patients. The ST group provides practitioners with a closer analog to the family of origin, which appears to add power to the experiential and cognitive interventions of ST and offers a microcosm of the "outside-of-therapy" world in which to practice behavioral pattern-breaking. There are some disagreements among the models of ST groups represented here (e.g., whether psychodynamic and ST therapist approaches can be reconciled, how outside group contact should be dealt with, how the group itself is employed as an agent of change). These and other issues raised still need to be investigated empirically. The various group models have varying levels of support by outcome studies. The large effect sizes reported (Farrell *et al.*, 2009) and observed clinically (Reiss *et al.*, submitted; van Vreeswijk, *et al.*, unpublished) strongly suggest further exploration of the promise of ST in groups for difficult-to-treat patient populations.

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