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Leading Article

SCHEMA THERAPY: THE NEXT GENERATION, BUT SHOULD IT CARRY A HEALTH WARNING?

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Abstract. Cognitive behaviour therapists working in the field over the last 10 years will have witnessed a shift to more schema focused forms of therapy. While these approaches have been introduced to treat people with personality disorders, they have also had a strong influence on the treatment given to people suffering from Axis I disorders. Indeed, it is my impression that many therapists are now of the opinion that they are not doing proper cognitive behaviour therapy (CBT) unless they have undertaken a detailed history of a patient's early childhood and, along the way, unearthed a couple of core beliefs. This paper outlines some of the pitfalls concerning the shift of emphasis towards schema focused techniques. While it is acknowledged that schema work is a development of ''traditional'' CBT, it is proposed that schema therapy is being employed without adequate assessment of its appropriateness, especially when used in primary care settings with people with no prior history of psychiatric problems. This paper provides some anecdotal details about therapists' difficulties in using schema techniques. These examples stress the need for good supervision, highlighting the responsibility of therapists to ensure that the patient receives the most appropriate form of therapy. This work recognizes the importance of schema focused approaches, but suggests that they are being used too pervasively, and too often by people with neither sufficient training, nor adequate grounding, in the empirically validated ''traditional'' CBT approaches.

Keywords: Schema, therapy, assessment, problems.

The evolution of CBT

Schemata, deep structures, core beliefs, core structures, tacit knowledge; these are just some of the terms that have been used to describe a person's underlying set of beliefs. It is theorized that these constructs organize a person's knowledge about him/herself, the world, and the future. There is much debate regarding the above terms: for example, how are the structures able to influence behaviour? Are they held outside of awareness? If unconscious, how are they assessed? When, and how, are they formed? How can they be measured?

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Despite a lack of clarity concerning the concepts, according to Vallis (1998) their use in CBT has heralded the inception of the ''second generation'' of cognitive therapies.

Perris (2000) considers that the early versions of CBT (1st generation) worked with surface-level structures. In his review paper, he compares early forms of CBT with some of the more recent approaches. He provides details based on his extensive experience of various types of Axis II presentations. It is his view that when one is dealing with more complex presentations, therapy needs to be adapted in terms of structural, process and conceptual features in order to deal with core beliefs:

> Such an adaptation has implied a shift of focus from relatively peripheral basic assumptions to more central core beliefs. This type of change might be described as a shift from a bottom-up (that is working at the symptom or content level) to a top-down approach that implies working with deeper levels of cognition. (Perris, 2000, p. 101)

As part of a recommended treatment package, he suggests admission to specialist units from between 6 month–2 years; thus one assumes he is recommending this approach for people with severe difficulties.

Perris suggests that 1st and 2nd generation approaches differ with respect to the role of the therapeutic alliance. In terms of Bordin's (1979) three components of therapy: bonds, goals and tasks, Perris considers 1st generation (bottom-up) approaches are goal and task oriented, wheras 2nd generation (top-down) approaches place greater emphasis on the bond. Indeed, it is suggested that an essential role of the therapist using a top-down approach is to form a ''secure base'' for the patient (see Bowlby, 1988). A further distinction concerned the degree to which historical and developmental details were examined, and used, in the two approaches. Perris, in line with many schema focused proponents (Young, 1994), believes that a patient's early history is an important area, requiring detailed focus:

> A major difference between followers of a bottom-up or a top-down approach, however, might consist of the extent to which knowledge about developmental issues is actually utilized in the practice of therapy. (Perris, 2000, p. 102)

In summary, the field of CBT appears to have evolved into a 2nd generation of treatment approaches. These approaches have developed owing to the perceived inadequacies of the standard forms of ''here and now'' therapy, and especially in response to problems arising from the treatment of people with Axis II disorders. In general, the top-down approaches focus more on the development and maintenance of schemata. They also place greater emphasis on the therapeutic alliance, and use the relationship within the therapy as a mediator of change.

Before moving on to discuss the impact of top-down approaches on CBT, it should be acknowledged that the 1st generation clinicians made clear reference to the role of underlying cognitions in therapy. For example, Beck, Rush, Shaw and Emery (1979) suggested that people who are depressed had stable cognitive structures (assumptions, core beliefs, schemata). It was also believed that these structures may have developed in early childhood and predisposed people to interpret themselves, their world and future in dysfunctional ways. It was stated explicitly, however, that the treatment of Axis I and II disorders differed:

> The use of childhood material is not crucial in treating the acute phase of depression or anxiety, but it is important in the chronic personality disorders. (Beck et al., 1979, p. 91)

Thus the so-called 2nd generation of therapies merely mark an evolution of focus rather

than a revolution in theory. That said, some of the developments within schema treatments (e.g., aspects of Young's (1994) schema focused work – notions of schema compensation, maintenance and avoidance) evidently *do* represent useful developments.

Impact of schema focused therapies on CBT

One of the positive consequences of greater attention being paid to schemata has been the establishment of more comprehensive conceptualizations. These models help inform the therapist better about the development and maintenance of patients' problems, and assist in identifying obstacles to effective change. Another positive feature resulting from the introduction of schema therapies is the explicit acknowledgement that structural changes may be necessary with respect to the therapy sessions (e.g., number, length, frequency, pacing of sessions). Further, their introduction has helped in the development of approaches for treating people suffering with chronic problems. Many therapists working in secondary or tertiary settings will have found the more comprehensive conceptualizations used in schema approaches helpful, particularly as many of their patients will have experienced childhood difficulties and life-long interpersonal difficulties.

Although there are some clear benefits associated with the greater emphasis on underlying structures, it is essential to remember that care must always be taken when working at the level of schemata, whatever form of CBT one is engaging in. The following example illustrates the sort of problems one can get into when working at this level of belief, especially when one lacks experience.

Recently, one of my trainees said to me: ''It was relatively easy to get his schema out, but I didn't know what to do next.'' While acknowledging my responsibility as a supervisor for this situation arising, I was alarmed at witnessing the potentially destructive use of schema work on this patient. I was particularly concerned to hear that the patient had been allowed to leave the session, now convinced he had always seen himself as ''worthless''. During the session, the trainee had not made any attempt to get him to re-evaluate the belief: apparently, the patient walked from the room visibly shaking. I discussed this issue with my trainee at the next supervision session. She recognized the problem immediately, stating that this difficulty had arisen previously.

This admission, along with similar scenarios reported by my colleagues, caused me (as a supervisor on a national CBT course) to question the way we were teaching and supervising trainees in the use of schemata in CBT. At the very least we should be warning inexperienced therapists that the therapy is more difficult to do than it initially appears.

While supervisors must bear a lot of responsibility regarding allocation of suitable patients, adequate screening, quality of supervision, etc, the trainee also needs to be able to access his/her own level of skill. Indeed, he/she must be careful not to work outside his/her zone of competence. Admittedly, without sufficient experience, this can be a difficult judgement, especially as some of the schema techniques appear deceptively straightforward. For example, eliciting negative cognitions in Axis II patients is often relatively easy (especially compared to changing such cognitions), even by therapists with limited experience. However, the ready accessibility of negative beliefs can cause problems for the unskilled, perhaps leading a depressed patient to endorse prematurely an incorrect schema proposed by his/her therapist. It is hoped that a more competent therapist would have taken greater care to ensure

that the elicited schema was arrived at collaboratively and was truly consistent with the conceptualization.

The present example examines the problems observed with trainees. However, as a supervisor of qualified cognitive behaviour therapists (diploma and certificate level), it is common to witness difficulties even with these more experienced clinicians. One of the most frequent issues is the lack of preparatory work engaged in by the therapist prior to working on the schemata. Indeed, it is common to see the therapist attempting to get the patient to re-evaluate his/her belief without assessing the ramifications resulting from the belief being exposed, challenged, and weakened. A good therapist will see the need to underpin the patient's belief network through enhancing the role of functional cognitions prior to working on the core schemata. Thus the responsible therapist will have engaged in sufficient work to be able to predict how the patient may respond once the dysfunctional schema has been successfully challenged. The therapist will also know what coping strategies the patient possesses in order to deal with this new perspective.

The above example dealt with the unskilled use of schema work in an appropriate setting (i.e., working with a person with an Axis II disorder). However, a further issue concerns the use of schema therapy in inappropriate settings. Indeed, although developed for people with personality disorders, these approaches seem to be becoming the preferred approach for people with Axis-I disorders too. This is particularly worrying owing to the fact that, despite being far more intrusive, there is little evidence that they are more effective than non-schema focused treatments (Jacobson & Gortner, 2000). This particular issue is worth highlighting in view of the recent literature on Stepped Care models in psychotherapy (Haaga, 2000; Davison, 2000). Stepped care models are attempts to provide effective treatments using lowest intensity interventions.

> The link to stepped care is that the most intrusive/intensive/expensive interventions should be implemented only when less intrusive ones have failed, or in light of the evidence, they are likely to serve the patient's best interests. (Davison, 2000, p. 583)

Stepped care philosophy would therefore suggest that when one is treating an Axis I disorder, the therapist is under a ''moral'' obligation (Davison, 2000, p. 583) to use a ''1st generation'' CBT approach.

On the issue of effectiveness, it is important to note that there is sparse empirical evidence regarding the efficacy of many of these schema therapies (see Turkat & Maisto, 1985). In Morrison's (2000) single-case report, outlining the use of schema-focused therapy, she acknowledged this issue: ''. . . There has been little in the way of treatment reports supported by outcome data.'' (p. 270). Indeed, despite the wealth of literature in the area (Davidson, 2000; McGinn & Young, 1996; Young, 1994; Padesky, 1990, 1994; Linehan, 1993; Beck, Freeman & Assoc., 1990), there has been a lack of empirical work of good quality testifying to its comparative efficacy. A notable exception to this was a study conducted by Jacobson et al. (1996), which undertook a component analysis of CBT for depression, comparing a treatment that contained schema focused techniques with two non-schema focused approaches. The experimental study compared three treatment conditions (total $N = 151$): behavioural treatment (BA), a treatment using behavioural therapy and work on automatic thoughts (AT), and a *full CT* condition.

> The *full CT* (my italic) treatment included not only work on BA and AT, but also a direct focus on identifying and modifying core depressogenic schema. According to the cognitive

> theory of depression, CT should work significantly better than AT, which in turn should work significantly better than BA. (Jacobson et al., 1996, p. 296)

However, despite using experienced therapists and patients with chronic depression (mean number of previous episodes 5, *SD* 5), there was no evidence that *full CT* was better than either of the other conditions. This observation was also true at 6 month follow-up.

Despite lacking clarity and empirical support, schema focused therapies seem to be becoming increasingly popular, both in terms of theory and practice. Evidence regarding this popularity comes from three sources: my work as a supervisor and tutor on a CBT course (i.e., the contents of videos submitted for marking, case studies and essays); from discussions with peers; from requests for talks at local universities and clinical services. So why are schema focused approaches so popular? One obvious reason is that these approaches are often more interesting for the therapist. The 1st generation approaches may seem rather pedestrian compared to the excitement of unearthing life long core beliefs. Second, there is the issue of ''therapeutic power''; there is often a great feeling of power when one gets to the core of a person's problem quickly and incisively. And it is wonderful to hear the patient say to you ''It's true, I do see myself as inadequate, but I never realised that before''. The widespread use of 2nd generation approaches may also relate to some form of collusion, whereby a schema focused approach often appears to shift the blame and responsibility concerning problems away from the patient, and backwards in time towards parents, guardians, teachers and siblings. Lastly, the popularity of schema focused therapies may also relate to the fact they share many similarities with other forms of therapy like Cognitive Analytic Therapy and Brief Psychotherapy. These shared features make them readily accessible and acceptable, and perhaps more credible for those who come from other therapeutic orientations.

Before concluding, it is worth making some final points. First, one must remember that, while every person will have schemata (which may be dysfunctional in certain situations), these beliefs may not be at the root of his/her current problem. Therefore, before one engages a person in any form of schema therapy, a careful assessment of its appropriateness must be made: for example, is this the right form of therapy for this presentation? Am I the right therapist to do the therapy? (Do you have the skills, and the resources – remember the treatment may last years). What are my goals (changing the core belief, or improving coping style) with respect to the treatment?

Second, it is also important to remember that people's belief systems are influenced by many elements, such as cultural and developmental features. In my own work with older adults, it is often cultural and age related beliefs, rather than early maladaptive schemata (Young, 1994), that have the strongest influence on a person's perception of him/herself (James, 1999).

Conclusion

CBT has influenced a number of other therapeutic traditions, including behaviour and analytic therapy (brief psychotherapy, cognitive analytic therapy), thus schema focused approaches represent only one strand of development. Over the years, CBT has readily incorporated effective techniques from other therapies while emphasizing the importance of empiricism. This is one of the reasons it has become the psychological treatment of choice

for many of the Axis I conditions (Roth & Fonagy, 1996). Notwithstanding this achievement, the traditional (1st generation) approach, as described by Perris (2000), has had limited success with Axis II disorders. This has led to adaptations, which have included a greater emphasis on schema work. It is important to remember that schemata, and schema change techniques, have been an integral part of CBT for many years, and have provided valuable concepts and tools in our therapeutic arsenal. Nevertheless, the jury is still out on the efficacy of treatments labelled as schema focused therapies. Despite this, these new (2nd generation) approaches are now having a major impact on CBT in general. In fact, schema focused work may be becoming synonymous with CBT, and it is becoming increasingly common to find that these more intrusive and less parsimonious approaches are being used with people with acute depression and anxiety. This trend should give concern, as working at this level of cognition is fraught with problems and may potentially harm some of our patients.

As a final illustration, on one of the videos I assessed last year as part of a project on therapeutic competence, I was concerned to hear an Axis I patient, who had just been administered schema-focused therapy, say: ''Before coming into therapy, I didn't realize that I had so many problems . . and that I was such a sh*t.''

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