

Therapy in Confined Spaces:  
Forensic Schema Therapy with  
Severe Personality Disorder

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Therapy in Confined Spaces

- The emergence of the laws for *post sentence detention and supervision* specifically targeting sexual offenders emerged in early 2000's
- Qld DPSOA 2003 was first though followed by similar laws in Western Australia & NSW in 2006, Victoria 2009, and Northern Territory 2013 (McSherry, 2013)
- Similar to 'Sexual Predator Laws' in the USA, which had been around since 1990's, however, it wasn't until the early 1990's that such schemes became increasingly prevalent throughout the USA

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Post Sentence Preventive Detention & Supervision: Sex Offenders

Impetus:

- **Exceptionalism:** the notion that sex violence – at least in some forms – is different in kind from the common expression of antisocial behavior
- Sex offending was *rampant*, posed a *more insidious threat* to the welfare of society than other criminal behaviours, and as such, needed a variety of interventions that were *regulatory* in nature (Janus & Prentky, 2009)
- The '*medicalization*' of risk / 'dangerousness'

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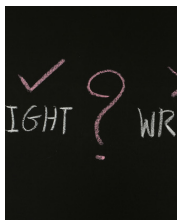
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### Post Sentence Preventive Detention & Supervision: Recidivism rates



- Recidivism rates are relatively low:
- World
    - Hanson & Bussiere (1998): **13.4%** (n = 23,393)
    - Hanson & Norton-Bourgon (2004): **13.7%** (n=31,000)
    - The Department of Justice (2003): **5.3%** 3-years after release (n=9,691), sex offender recidivism **37% less** than non-sexual offender populations for all crimes
  - In Qld
    - Smallbone & McHugh (2010): **4.9%** (n= 409)

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### Post Sentence Preventive Detention & Supervision: recidivism rates

- Risk reduces over time e.g. Hanson, et. al. (2014), n=7740
  - Risk **highest** during the **first few years after release**, and decreased substantially the longer individuals remained sex offense-free
  - This pattern was particularly strong for the high-risk sexual offenders (defined by Static-99R scores). Whereas the **5-year sexual recidivism rate for high-risk sex offenders was 22%**, this rate **decreased to 4.2%** for the offenders in the same static risk category who remained offense-free in the community for 10 years
  - Low risk offenders were consistently low (1-5%)

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### Post Sentence Preventive Detention & Supervision: Sex Offenders



- Risk Assessment has significant progress since 1980's
  - Monahan (1980) "clinicians **wrong two-thirds of the time** in making predictions of dangerousness..."
- Current risk assessment process will use a combination of static (historical) and dynamic (changeable) variables

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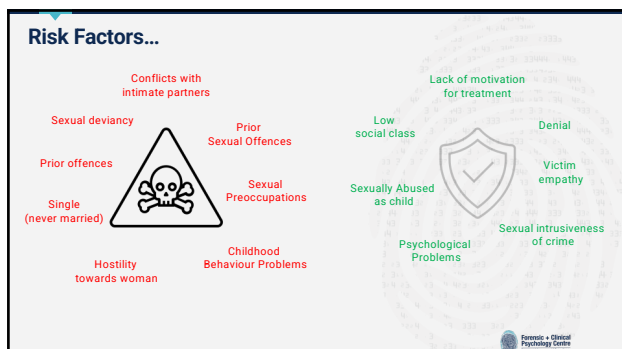
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Post Sentence Preventive Detention & Supervision: Sex Offenders

“We are not now and probably **never will be in a position to be able to determine with certainty who will or will not engage in a violent act.** Relying on a range of empirically supported risk factors, though, we can make a reasoned determination of the extent to which those we are assessing share factors that have been found in others to relate to an increased level of risk”

(Mullen & Ogloff, 2009)

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Options for flagged offenders in QLD

- **High Intensity Sexual Offender Treatment Program (HISOP):** 9 months program is for high-risk sexual offenders; usually delivered on a rolling basis allowing continual entry and exit of participants throughout the program (there is also a medium intensity program, MISOP)
- **Sexual Offending Maintenance Program (SOMP)** is to be completed by graduates of a sexual offending program

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### Sex Offenders: Treatment Options in Qld



"Probably works"  
Hanson et. al., (2009) Treated 10.9% vs Untreated 19.2%  
**In Qld:** Smallbone & McHugh (2010): Treated (2.9% vs 9.6%\* *nonsexual violence*; 20.9% vs 32.3%\* *any recidivism* ; **but not for sexual (3.2% vs. 6.0%)**)

- Characteristics of 'working treatment':**
- Risk – Needs – Responsivity
  - CBT/RP
  - **Characteristics of therapist\*\*** (i.e., warmth, empathy, non-judgmental, respect) (Marshall, et.al., 2002)

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### Post Sentence Prevention Detention: Qld

- Post-sentence preventative detention enable application to be made to the Supreme Court, prior to the offender having completed a finite sentence, for an order for continuing detention in prison or continuing supervision in the community
- Risk assessments by **two (2) psychiatrists** evaluating whether the offenders continues to present an **unacceptable risk of reoffending**
- **Orders** can be made that stipulate that offenders are required to abide by specific conditions including, restrictions of accommodation, curfews, **attending treatment**, complete drug tests, electronic monitoring,

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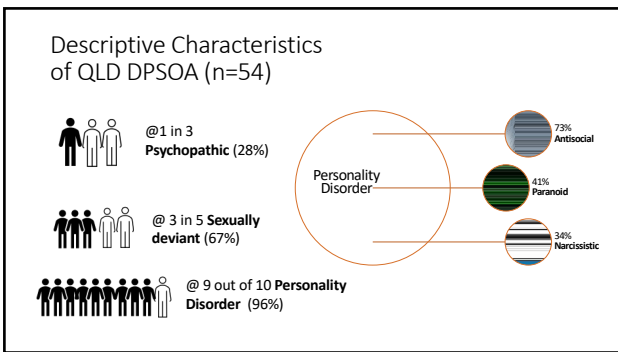
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Compared to everyone else (e.g., Aklers, et. al., 2011; NOMS, 2015; Santilla, et. al., 2010)

	General Pop	Clinical Pop	Psychiatric Hos Pop.	Prisoners	DPSOA
Personality Disorder	5 – 10%	20 – 30%	30 – 40%	60 – 70%	<b>96%</b>
Psychopathy	0.75 - 1%	-	-	10 – 15%	<b>28%</b>
Sexual Deviancy	3 – 9% (males)	-	-	-	<b>67%</b>

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### Characteristics

- Many DPSOA offenders struggle to complete the group programs or indeed engage in any offence specific treatment whilst in custody
- They either refuse, are removed from the group program, drop-out, or simply evaluated to have not benefited

"Life looks different three standard deviations from the norm.."

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### Forensic rehabilitation: Risk-Needs-Responsivity Model (RNR)

- The **RNR model** is a widely used framework guiding treatment of offending populations. The model is based on extensive research into the factors which predict recidivism – these are the key dynamic (i.e., changeable) risk factors that are most strongly related to recidivism
- Proposes that **intervention with offenders works best** when:
  - **Risk:** Targets high-risk offenders
  - **Needs:** Targets the characteristics that are changeable and related to risk
  - **Responsivity:** Uses methods and techniques that are accessible to the patient (i.e., accounting for personality, intellectual functioning, mental health problems etc.)

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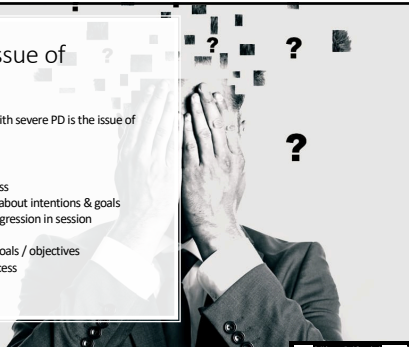
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### Severe PD: the issue of responsibility

- One of the biggest challenges with severe PD is the issue of responsibility
- Typically:
  - Mistrust you and the process
  - Exploitative and deceptive about intentions & goals
  - Interpersonal hostility & aggression in session
  - Impulsivity
  - Resistance to therapeutic goals / objectives
  - Attempt to control the process
  - Detachment



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### Schema Therapy

- Schema Therapy (ST) emerged in early 1990's as treatment for personality disorder (PD) resistant to 'traditional' treatments
- Innovative and integrative type of psychotherapy as it incorporated techniques & ideas from other therapy approaches – cognitive, behavioural, psychodynamic
- Not eclectic therapy – has underlying theory
- Emphasis that adverse early developmental experiences – 'unmet core emotional needs' leading to formation of 'early maladaptive schemas' (schemas)
- Schemas are mal-adaptive ways of thinking, feeling & behaving that when 'triggerred' (activated) generates significant distress



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### Schema Therapy

- ST normalises rather than pathologizes personality disorders, in that, **everyone** has schemas, coping styles & modes in some clients these are more rigid & extreme
- Schemas develop in childhood, are self-defeating, and strengthened and elaborated throughout life
- Are dimensional, have differing levels of severity & pervasiveness
- The more entrenched the more negative affect generated, and triggers exists



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### 18 Schemas (Young, et al., 2003)




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### Schema Therapy

- ST focused on modifying schemas, maladaptive coping mechanisms & modes
- Uses cognitive and behavioural interventions, however, emphasis emotional change through the use of experiential techniques (chair work, imagery) and the therapeutic relationship (limited reparenting)
- Evidence of effectiveness with **Borderline PD** (Farrell et al., 2009; Giesen-Bloo et al., 2006; Nadort et al., 2009) & **Cluster C PDs** (Bamells et al., 2011)

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### Modes

- Refers to an emotional state or '**part-of-the-self**' that temporarily dominates a person's thoughts, feelings, and behaviour (Rafaeli, et al., 2011)
- Clients with severe PD's typical flip between intense emotional states = intense anger to vulnerability to detachment to suspicion
- Mode concept incorporated into ST from early 2000's




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### Forensic Schema Therapy

- Relatively new innovation pioneered by David Bernstein and colleagues in the Netherlands in the mid to late 2000's
- Introduced the so-called forensic schema modes:
  - the **bully & attack**;
  - the **self-aggrandizer**;
  - the **predator**; and,
  - the **conning-manipulator**
- Working with severe personality disorder and helping make sense of offences that often can appear inexplicable
- Bernstein's recent RCT - Bernstein DP et al (2021). Schema therapy for violent PD offenders: a randomized clinical trial. **Psychological Medicine** 1–15.
- Used in Victoria Corrections as the treatment modality for offenders labelled

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### Forensic Schema Therapy (FST) (Bernstein, et. al., 2019)

- Places a much greater emphasis on the modes & conceptualises the **'responsivity'** challenges often experienced as evidence of the patient's maladaptive coping modes, specifically the overcompensating modes
- These maladaptive coping modes typically have emerged in childhood in challenging circumstances, and served to help the patient feel safe, get their needs met, and generally survive in the world
- Bernstein et. al. (2007) identified forensic coping modes: Bully & Attack, Coning Manipulator, Predator, and Self Aggrandizer

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**The Bully & Attack Mode** (Bernstein, et.al., 2007, 2019)

**Key Signs**  
 Presents in intimidating, threatening & aggressive manner –both verbally & non-verbally  
 Objective of behaviours is to *put someone in their place, to make them feel unsafe or scared*  
 Different type of anger to angry child or angry protector  
**Function:** Sometimes to overcompensate for feelings vulnerability, powerlessness, etc  
**Typical feelings:** Scared, threatened, unsafe

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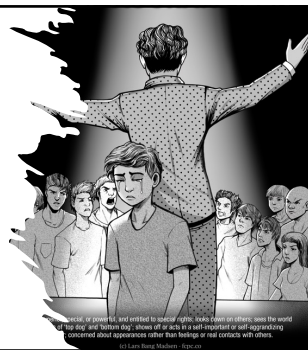
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**The Self Aggrandizer Mode** (Bernstein, et.al., 2007, 2019)

**Key Signs:**  
 Likes to present self in a good light – tells stories about his specialness, superiority, normal rules don't apply to me  
 Experienced by others as arrogant, likes to talk about self  
 Puts others down, including the therapist  
**Function:** Sometimes to compensate for feeling defectiveness, shame, worthlessness  
**Typical feelings:** Annoyed, put-down / belittled, anxious to impress



...fickle, or powerful, and entitled to special rights; feels pain or illness; sees the world as unfair and believes they deserve it; reacts in a self-protective or self-aggrandizing manner about experiences rather than feelings or real contacts with others.  
 © Sam Rind, Medium (2019)

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**THE CONNING MAN**

**The conning manipulator mode** (Bernstein, et.al., 2007, 2019)

**Key Signs:**  
 Uses indirect methods to get what he wants.  
 May present as a perfect patient, flatter the therapist and the therapy. May make up stories to garner sympathy  
 May try to get favours, be owed something or encourage the therapist to violate boundaries in one way or another to have something over them  
 Lies  
**Typical Feelings:** Confused, things don't add up, manipulated



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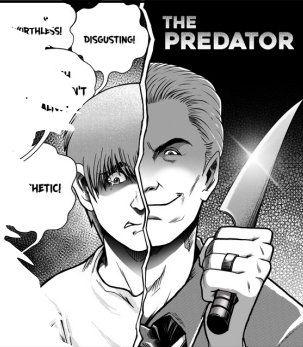
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The Predator (Bernstein, et.al., 2007, 2019)



**Key signs**  
 In this mode the patient is cold and detached and determined (THINK Jason from Friday 13th or Michael Myers in Halloween). Violence is cold and calculating. Different than bully & attack where the motivation to intimidate and threaten, the predator is orientated to achieving a goal or objective.  
 Instrumental violence  
 Debt collect / hit man 'just business'  
**Typical feelings:** Scared, things aren't right, unsafe, the other person is unreachable

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Sources of Forensic Modes

A modeled strategy that has practical utility in a dangerous environment

*"My earliest memory was seeing my mother be raped by my dad... I was then also abused... when I went to the boy's homes, the older kids would get me, that happened, until I was the oldest and non-one could get me. I started raping the younger ones and it felt good to have control and power. In prison, rape became a strategy for control and power, not just pleasure although I enjoyed raping guys. I also knew that it scared the shit out of anyone who challenged me... You come for me, and I will get you eventually no matter what. I controlled everything." - Ray.*

Prominent Modes: **Predator / Bully & Attack / Self Aggrandizer Modes**

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Sources of Forensic modes

- A learned strategy that
- *"I am smarter than most of the guys in here. I know I can manipulate them easily and get them to give me things or do things for me without violence. I just pick a vulnerable one and tell them that a gang or someone dangerous is going to get them, but I can help them. I can protect them ... it'll cost you though, and I name my price... money, drugs, clothes, sex, anything really... it's easy" - Steve*
- Prominent mode: **Conning Manipulator**

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### Adaptations for to Forensic Modes

- FST places **greater emphasis on schema modes** compared to schemas (Bernstein, et al., 2019)
- Most forensic patients **reveal little vulnerability**, especially in the initial phase of treatment. Instead, their clinical presentation is dominated by maladaptive coping modes
- Behind this wall are the **Child modes**, which often reflect the histories of these patients
- One of the most important goals in FST is to eventually reach these vulnerable sides to **reprocess traumatic experiences, and provide for core emotional needs**



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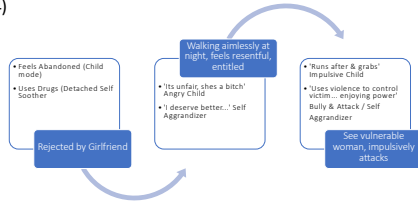
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### Offending & Modes

- FST understands offending as an unfolding sequence of modes, usually initiated by a vulnerable / child mode (Keulen-De-Vox et al., 2014)



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### Presence of specific modes as Risk Factors

- Structured risk assessment can only say so much, and the challenges with is identifying when someone is most at risk
- Typically determined by examining changeable characteristics
- The presence or absences and the degree of activation of a 'known offending sequence' provides relevant information about the level of risk that an individual may actually represent.

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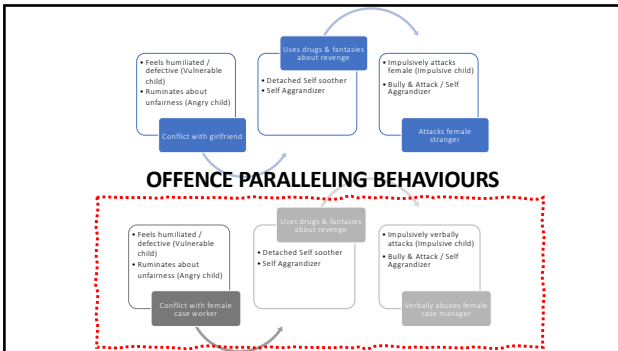
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Discussing forensic modes ...

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Case conceptualisation

- Victor (43 years) referred due to risk assessment outcome and impending parole application
- Convicted of Murder plus History of Violent Crimes
- Diagnosed - **Antisocial Personality Disorder with Narcissistic & Borderline** traits plus unspecified **Paraphilic Disorder**
- Substance Misuse Disorder, in remission in confined context
- Psychopathy Checklist Revised (PCL-R) 25 (Hare, 2003)
- Risk of Sexual Violence Protocol (RSVP) = high risk

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Case Study Example

- Grew up in foster home with large number of other children
- Foster parents **emotionally & physically** abusive (mistrust & abuse, emotional deprivation)
- From a young age felt different in a negative way (failure / defectiveness), was excluded by peers
- Drug, alcohol abuse early on
- Sexual preoccupation – porn use, 'peeping tom'
- Stalking, risk taking & violence used to get needs met

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Victor

**Temperament:**  
Bold, daring

**Childhood experiences**

Was placed into foster at birth  
Grew up in a big family  
Foster Parents were emotionally and physically abusive  
Atmosphere at home was one of fear 'walking on egg-shells'  
Little warmth, connection and attunement  
From young age was allowed to wander around neighborhood by himself  
Exposure to antisocial older peers / drug and alcohol abuse

**Unmet needs:** Lack of safety, protection, empathy, nurturing and attunement, provide no help with coping with problems

**Schemas:**

Defectiveness and Shame: I am a freak, and I don't belong  
Mistrust and Abuse: **People hurt and exploit you**  
Emotional deprivation: **Don't expect anything from anyone** – love, understanding, guidance  
Social isolation: **I am outcast**  
Abandonment: **People always leave** and I will be alone  
Subjugation: **You must yield to others or you will be punished**

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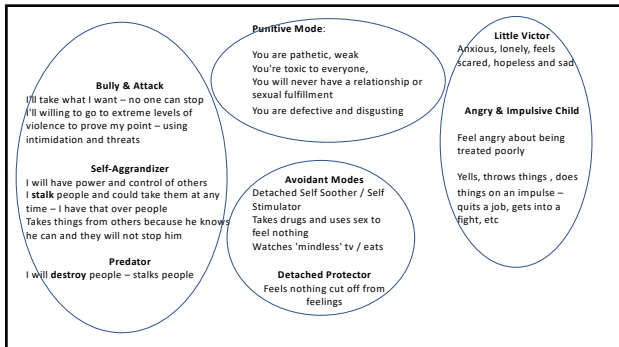
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Case example: Victor

- Function of offending
  - **Overcompensation** for a sense of powerlessness, defectiveness, exclusion and failure:
    - "The peeping tom behaviours made me feel relevant, powerful and capable. It was important that they did not know I was there "
    - "The feeling of power of having something over someone else and I could do anything to them, and they could not stop, was powerful. It made me feel like a type of god"

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Evidence base for Forensic Schema Therapy

**RCT:**  
 Bernstein DP et al (2021). Schema therapy for violent PD offenders: a randomized clinical trial. *Psychological Medicine* 1–15.  
 Bernstein, D. P., Nijman, H. L., Karos, K., Keulen-de Vos, M., de Vogel, V., & Luckner, T. P. (2012). Schema therapy for forensic patients with personality disorders: Design and preliminary findings of a multicenter randomized clinical trial in the Netherlands. *International Journal of Forensic Mental Health*, 11(4), 312–324.

**Published single case Studies:**  
 Chakhssi, F., Kersten, T., de Ruiter, C., & Bernstein, D. P. (2014). **Treating the untreatable: A single case study of a psychopathic inpatient treated with schema therapy.** *Psychotherapy* (Chicago, Ill.), 51(3), 447–461.  
 To be published single-case Study:  
 Madsen, L. & Bernstein, D.P. (2022). Untangling sexual murder: A Forensic Schema Therapy Case Conceptualisation of a child murderer. Book Chapter to be published.

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Schema therapy for violent PD offenders: a randomized clinical trial (Bernstein, et al., 2021)

- Compared ST to treatment-as-usual (TAU) at eight high-security forensic hospitals in the Netherlands (n = 103)
- Patients in **both conditions showed moderate to large improvements** in outcomes.
- **ST was superior to TAU on both primary outcomes** – rehabilitation (i.e., attaining supervised and unsupervised leave) and PD symptoms
- Findings **support the effectiveness of ST** for rehabilitating violent offenders with PDs

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**Forensic Schema Therapy - Key Points**

- Emerged mid-2000's with adaption of ST mode concepts to forensic patients and contexts
- Forensic contexts have higher prevalence of ASPD, NPD, BPD & Psychopathy – consequently emotional states including aggression, dishonesty, ruthlessness, etc.
- Adaptations – focus on modes, rolling with the challenges of poorly motivated patients, focus on offending / risk factors
- Forensic contexts present unique challenges for therapist, patient & the therapy



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**Thank you!**

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