Group Schema Therapy

Borderline Personality Disorder: a Catalyst to Mode Work

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OUR BACKGROUNDS

Joan

- Psychodynamic – U of Michigan 1968-72
- Behavioral – WSU - 1972-1978
- Personal construct/Social learning – Low 1975
- Experiential – Bioenergetics 1981-85

Ida

- Developmental Psychology – U of Windsor 1967-70, 1982-5
- Bioenergetics – 1975-1985
- Core Energetics – 1980s

INTEGRATION BEGAN IN 1985
CONTINUES FOR 25 YEARS

1986

Marsha Linehan's first article on Dialectical Behavior Therapy in the *Bulletin of the Menninger Clinic*.

Michael Stone's long term follow-up study of BPD patients gives a grim prognosis for the disorder.

Larue Carter

Farrell, Shaw & Glennon form a study group to develop an effective treatment plan for an inpatient Debby B. with BPD who could not stay in a session for more than 10 minutes due to extreme distress.

1st Challenge

High Distress Level

They were too distressed to stay in one place for more than 10 minutes.

Solved with physical movement, kinesthetic awareness exercises & relaxation

2nd Challenge

Low level of Emotional Awareness

They did not notice pre-crisis levels of distress – global good & bad

They seemed to have no words to describe their emotional experience, making verbal psychotherapy difficult

They were missing critical emotional learning

EMOTIONAL AWARENESS

1987 – *Levels of Emotional Awareness*, Lane & Schwartz, American Journal of Psychiatry

1988 – *Techniques to increase emotional stability in Borderline Personality Disorder patients,* Farrell, Shaw & Glennon. APA Midwinter Conference on Psychotherapy, Scottsdale AZ

1994 – *Emotional Awareness Training: A prerequisite to Effective CB treatment for BPD* , Farrell & Shaw, Cognitive & Behavioral Practice

Experiential techniques in CBT and Therapy Integration were just beginning.

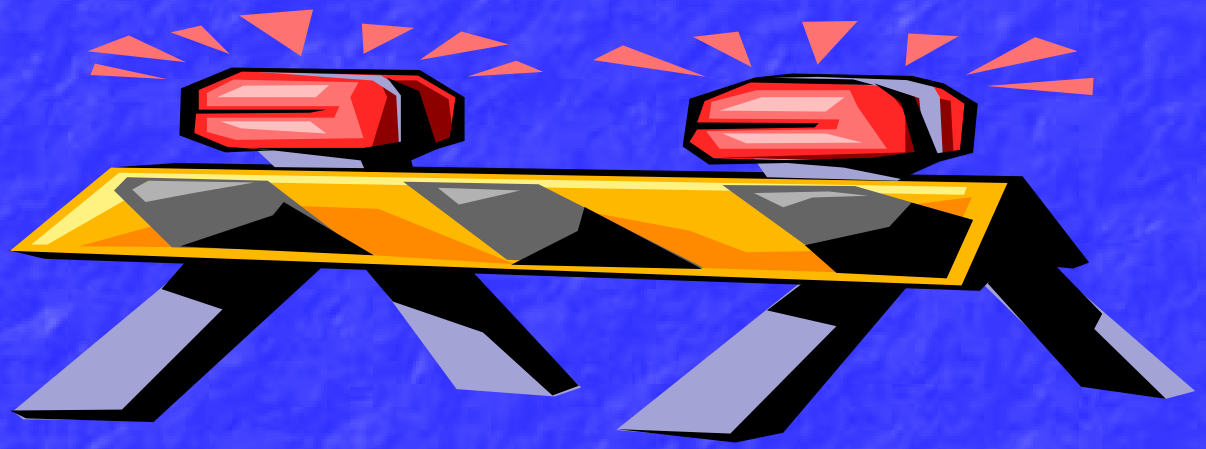
THE ALL BPD GROUP: ORDEAL OR OPPORTUNITY?

1988 – Larue Carter Outpatient Clinic group, weekly 90 minute sessions, one year.

We learned just how much individualization they needed and that we could not use their reactions as a gauge of effectiveness.

It took 6 months to get them into the same room for a session.

3rd Challenge: They did not use skills outside of sessions!



Schemas (self-defeating core themes or patterns) of defectiveness, vulnerability, failure, mistrust/abuse, etc. keep them from using their increased awareness or healthy coping skills that we taught them.

OUR EARLY GROUP MODEL

- Limited re-parenting
- Match developmental stage – emotional
- Strong focus on experiential work – Gestalt, Bioenergetics (kinesthetic), Imagery via breath-work
- Technically eclectic – unified guiding theory – social learning, person construct

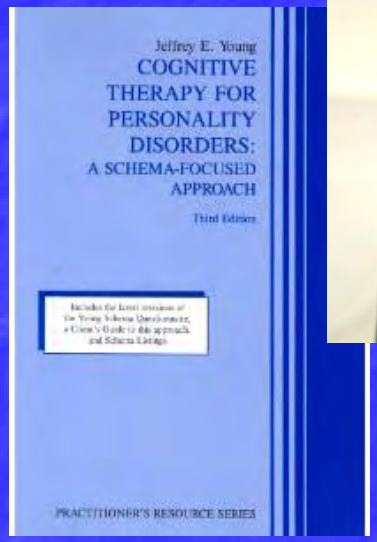
1ST GROUP MODEL

3 BASIC COMPONENTS:

1. Effective emergency plans (mode management plans)
2. Adequate emotional awareness (awareness of needs, feelings, modes)
3. Free enough of maladaptive schemas to take adaptive action (Healthy Adult)
4. We thought of this as “foundation work”

1990 First Schema Therapy Writing

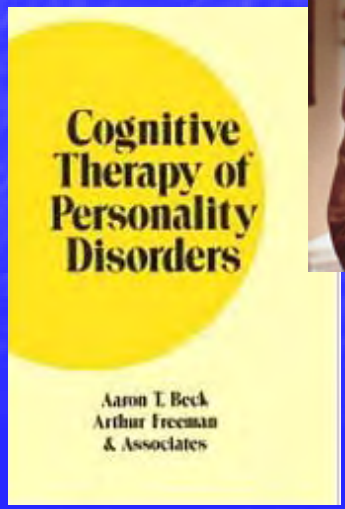
Cognitive Therapy for Personality Disorders – Schema Focused Approach, Jeffrey Young

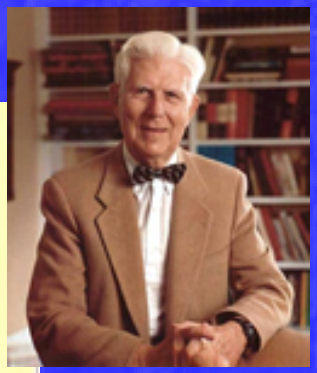


And the first CBT treatment for PD:

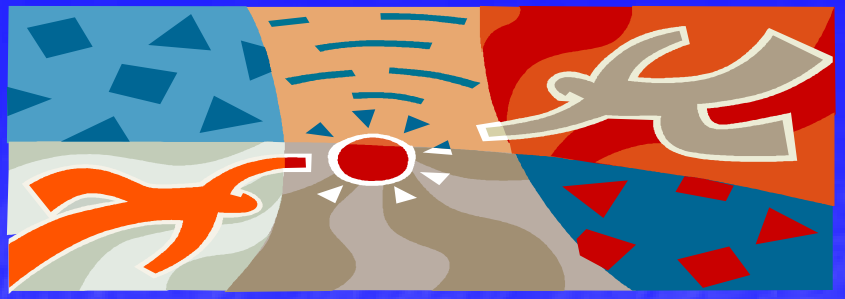
Cognitive Therapy for Personality Disorders. Beck, Freeman, et al

Includes : BPD Chapter by Arnoud Arntz





RANDOMIZED CONTROLLED TRIAL



OUTPATIENT LC

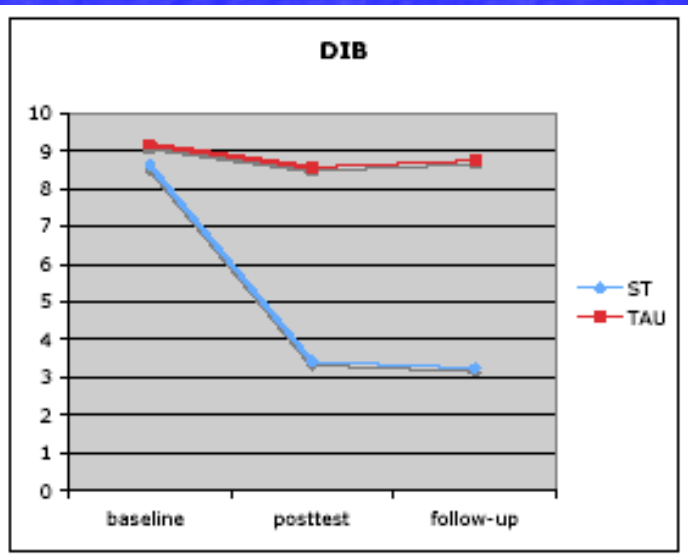
- Adjunct to individual therapy
- 8 months, 30 sessions
- 90 minutes long
- 1 session/week
- 6 month follow-up

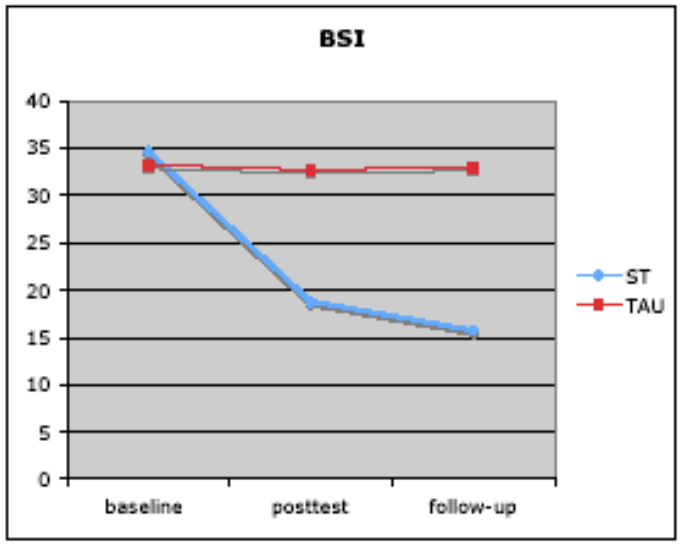
NIMH RO3

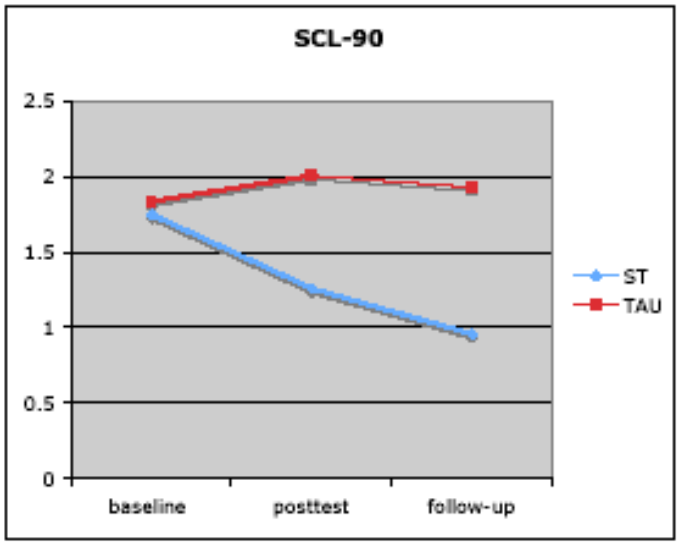
- BASE vs. TAU
- N=32
- 100% retention in treatment group
- No outside group contact

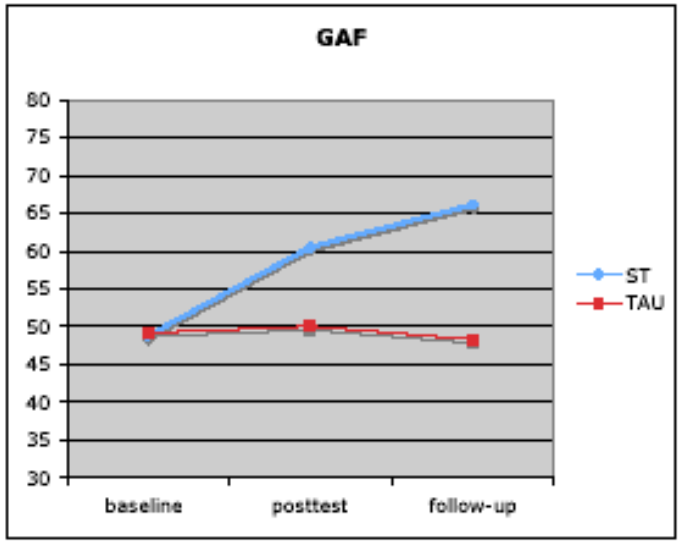
GROUP ST VS TAU FOR BPD

MAIN OUTCOME MEASURES (FARRELL & SHAW, 2009)









Mean ES
Cohen's d
ST = 2.62
TAU = 0.04

Recovery
ST 94%
TAU 25%

Drop-Out
ST 0 %
TAU 25%

Farrell et al. (2009),
J. Beh. Ther. & Exp. Psychiatry.

INPATIENT ST PROGRAM 1998

Phase I Open Trial 2004-2007

- N=42
- Limited re-parenting milieu
- Co-therapists in groups
- Strong, consistent team
- 15 weekly group sessions
- 1 hour of individual therapy
- 3 – 6 months long (mean 4.5)
- 6 month & 1 year follow-up

INPATIENT PILOT TREATMENT PROGRAM

Schema Therapy Groups – 10hrs per week

Conducted by 2 trained co-therapists

- Psychoeducation - about BPD & Schema therapy -1hr
- Schema Therapy -2 hrs
- Schema Skills -2 hrs
- Cognitive Mode Work -1hr
- Experiential Mode Work -1hr
- Mode Management Plans -1hr
- Mode Awareness -1hr
- Modes in Interaction -1hr

Individual Schema Therapy session – 1hr per week

RECOVERY FROM BPD IS POSSIBLE

Inpatient Pilot N= 42	TIME	
BSI SCORES	ADMISSION	POST
BPD = BSI>25	87%	15%
t = 13.84(41), p < .01		ES = 2.14
Mean GAF	28	58
t= -17.55(36), p< .01		ES = 2.89

OUTPATIENT RCT N=32	SCHEMA THERAPY		TAU	
TIME	Post	6 month	Post	6 month
% No longer meeting the DIB-R cut-off score for BPD	94%	100%	25%	17%
GAF ≥ 60	56%	88%	17%	8%

ES - Effect sizes using pooled SDs at baseline and mean change scores per condition. Cohen's d.

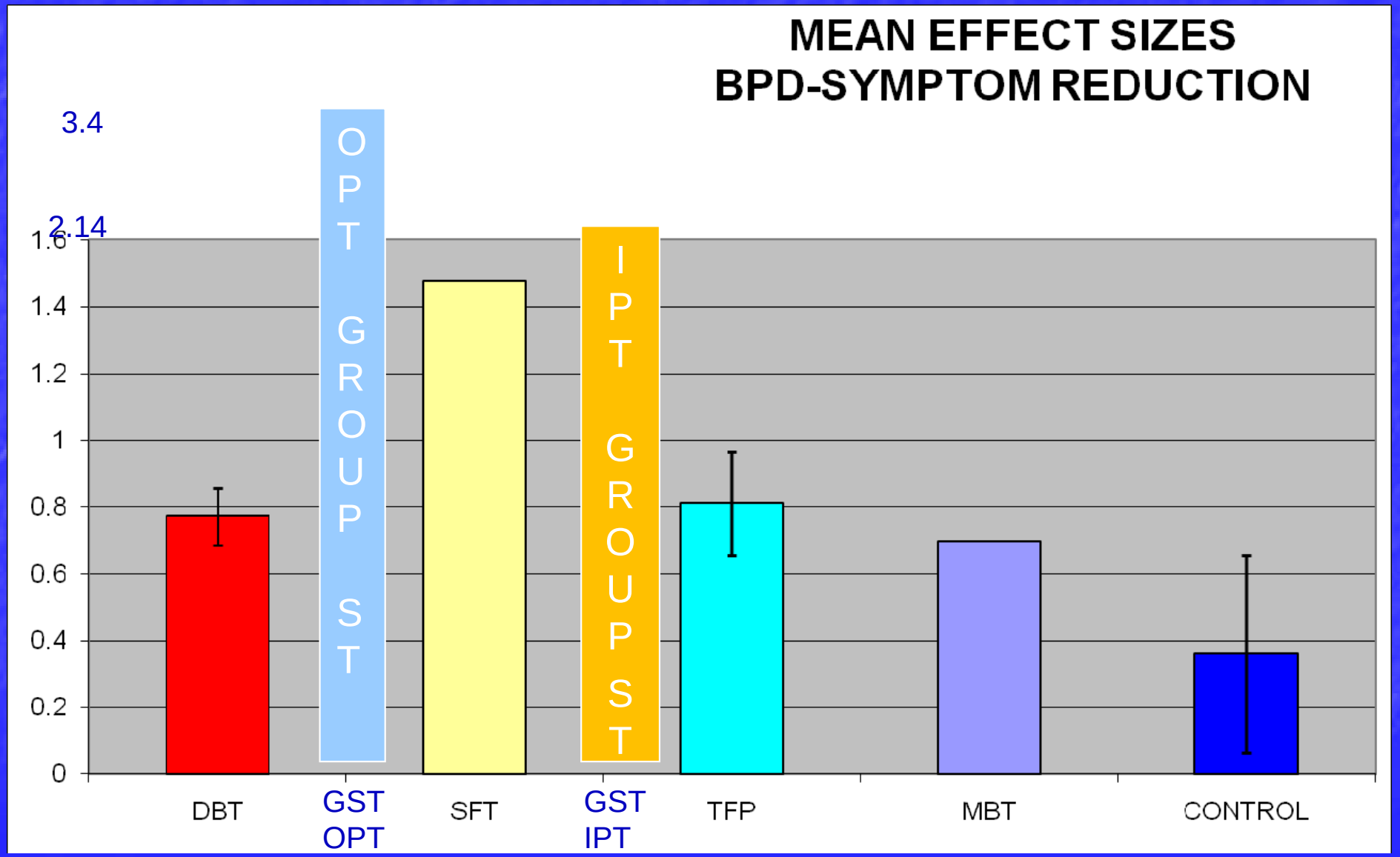
PATIENT SATISFACTION

In anonymous questionnaires Patients rated their overall satisfaction with the treatment as a percentage. The mean percentage rating was 92%

They were also asked to report what was most helpful to them in order of priority with the following result:

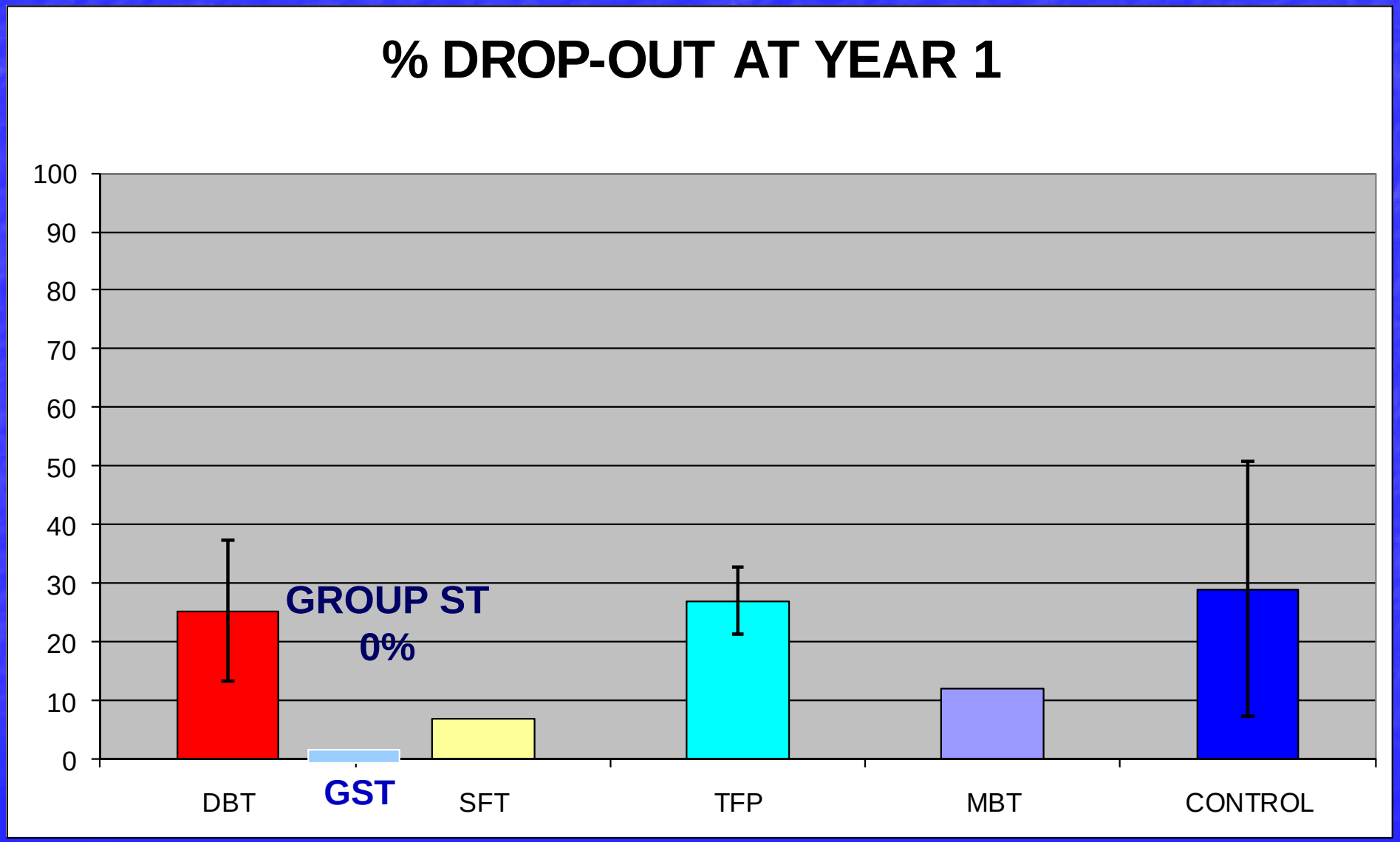
- "The feeling of belonging"
- "I felt understood for the first time"
- "There are people like me, so there is hope!"
- "Therapists were patient & consistent"
- "Therapists did not give up on me"
- "Learning effective coping skills"

MEAN TREATMENT EFFECT SIZES FOR BPD TREATMENTS



Arntz, 2010

DROP-OUT COMPARED STUDIES COMBINED BY MODEL



Arntz, 2010

BY 2008, WE DECIDE THAT OUR MODEL WAS A GROUP VERSION OF SCHEMA THERAPY FOR BPD.

YOUNG & ARNTZ AGREE -

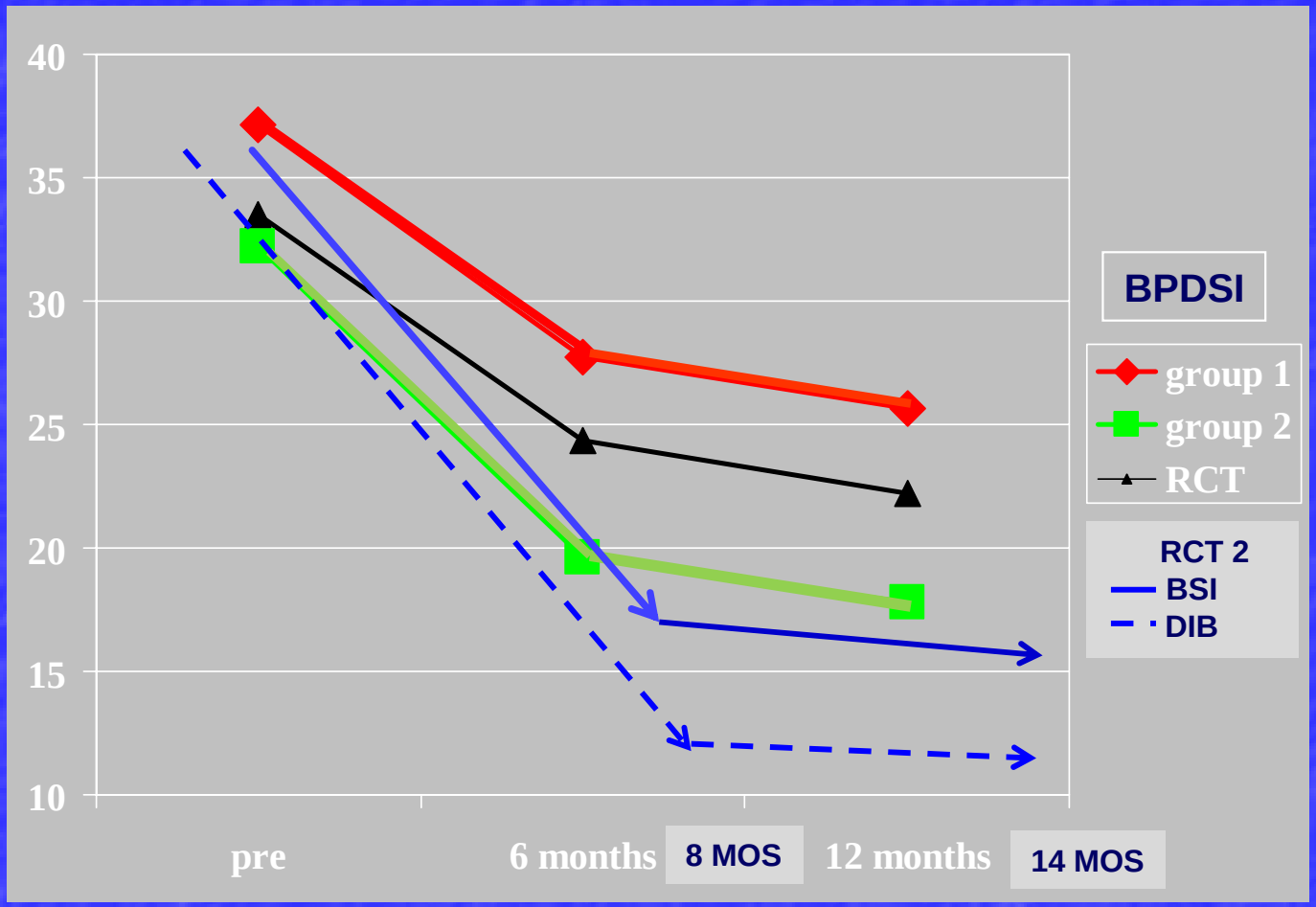
SO WE JOIN THE INTERNATIONAL SCHEMA THERAPY RESEARCH & PRACTICE COMMUNITY

CAN OUR RESULTS BE REPLICATED?

USA INPATIENT PILOT

DUTCH PILOTS

Pilots :Group & Individual ST Compared to RCT 1 Individual ST & RCT 2 Group ST



Effect Sizes Cohen's d

Group 1: Dickhaut & Arntz, 2010
6 months 1.28
12 months 2.40

Group 2: Dickhaut & Arntz, 2010
6 months 2.25

IND RCT1 Giesen-B, Arntz, 2006
6 months 0.75
12 months 1.10

Group RCT2 Farrell-Shaw, 2009
8 months: 2.48, 4.29
14 months: 2.96, 4.45

PRELIMINARY EVIDENCE THAT GROUP RCT EFFECTS ARE REPLICABLE !!

WHY SUCH LARGE EFFECT SIZES?

- The Curative Factors of groups directly address the main schema issues of patients with BPD (and many PDs).
- Group Catalyzes or Augments Schema Therapy's active ingredients – limited reparenting, secure attachment, emotional learning, schema mode change, generalization and transition to Healthy Adult function

GROUP SCHEMA THERAPY BENEFITS FROM THE POWER OF THE GROUP

BECAUSE IT GOES BEYOND DOING INDIVIDUAL THERAPY WHILE A GROUP PRIMARILY WATCHES

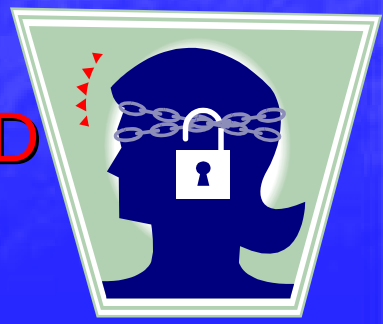
Group Curative Factors

- Cohesiveness (belonging)
- Corrective recapitulation of the primary family
- Altruism
- Installation of hope
- Universality
- Imparting of information
- Development of socializing techniques
- Interpersonal learning
- Vicarious learning
- Existential factors
- Catharsis

Schemas of BPD

- Abandonment
- Mistrust /abuse
- Punitiveness
- Unrelenting standards
- Defectiveness/shame
- Emotional deprivation
- Social Isolation/alienation
- Undeveloped self
- Emotional Inhibition

RELATIONSHIP BETWEEN CURATIVE FACTORS & BPD SCHEMAS



TO ACTIVATE GROUP CURATIVE FACTORS

group work must be as important as individual work.

Ways we accomplish this include:

- Individual patient focus is time limited and made salien for the group as a whole
- Focus moves between an individual's experience and modes common to the group
- We "weave" the common experiences of others into individual work & pull for group involvement
- One therapist is always attending to maintaining connection and the needs of the group.

GROUP CATALYZES ST COMPONENTS

1. Limited Reparenting
   - Experiences with peers feel more “real”.
   - Closer analogue of the family may intensify experiential work
   - Extended Family reparenting effects

2. Schema Change
   - Bigger stage for experiential
   - Vicarious learning powerful in getting through DP
   - The experience of belonging in the peer “family” is powerfully healing VC
   - Mode role-play with “full chairs” strengthens impact

3. Autonomy
   - Group acts as a “bridge” to life outside therapy
   - “Adolescent” level Mode work

GROUP ST MODEL #2 ADDED MODES

Abandonment Fears

THE MODE MODEL PROVIDES YOU WITH THE FOCI OF TREATMENT TO FOLLOW

Emptiness

Vulnerable child

Angry Child

Impulsive Child

Punitive **or** Demanding Parent

Detached Protector

MODE FLIPPING

EXPLAINS THE CLINICAL PRESENTATION OF PATIENTS WITH BPD

Reality connection - Dissociation Psychotic symptoms

2 THERAPISTS

N GROUP ST

ANGRY – IMPULSIVE CHILD MODES

DEMANDING

ANG CHANNELED

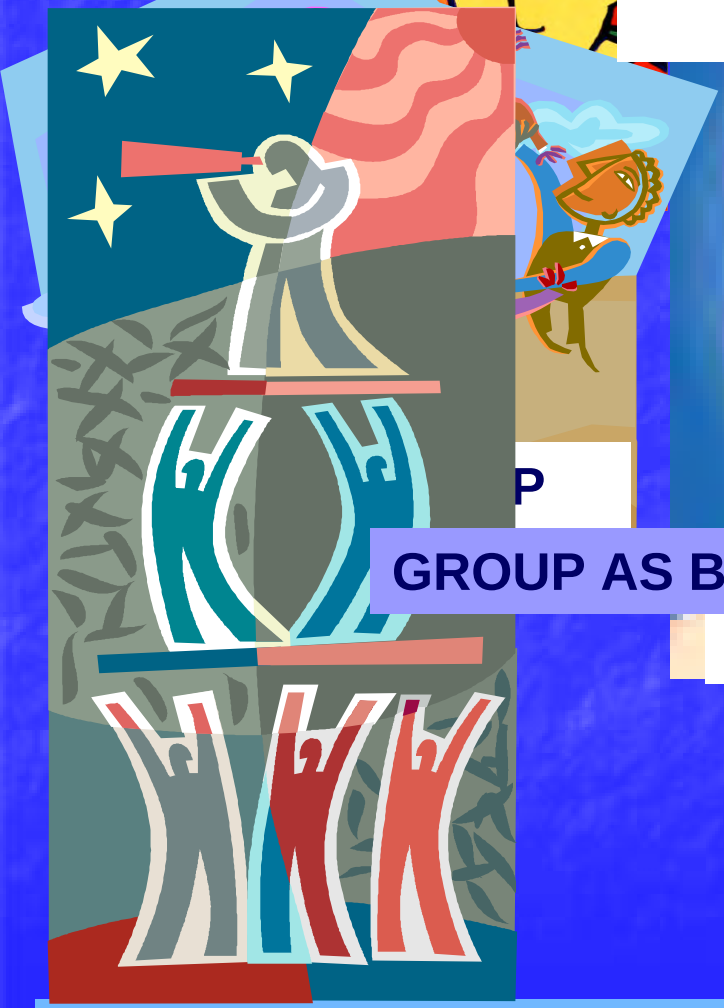
IMP ILD LIMITED

PARENT MODES

EMANDING

ANISHED

PUNITIVE



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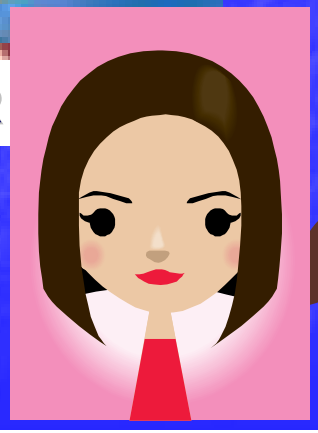
GROUP AS BRIDGE

DETACHED PROTECTOR



HEALTHY ADULT

HAPPY CHILD DEVELOPS

GOOD QUALITY OF LIFE

Group Schema Therapy

The theoretical model, the course & components are consistent with individual Schema Therapy (Young, 2003; Arntz, 2009)

Group requires some differences in application

- Limited reparenting of a large family vs. only child – multiple and at times conflicting needs exist
- Co- therapist team leads – a strong working relationship between therapists is needed
- Greater complexity – more modes simultaneously
- More balancing of structure & flexibility are needed

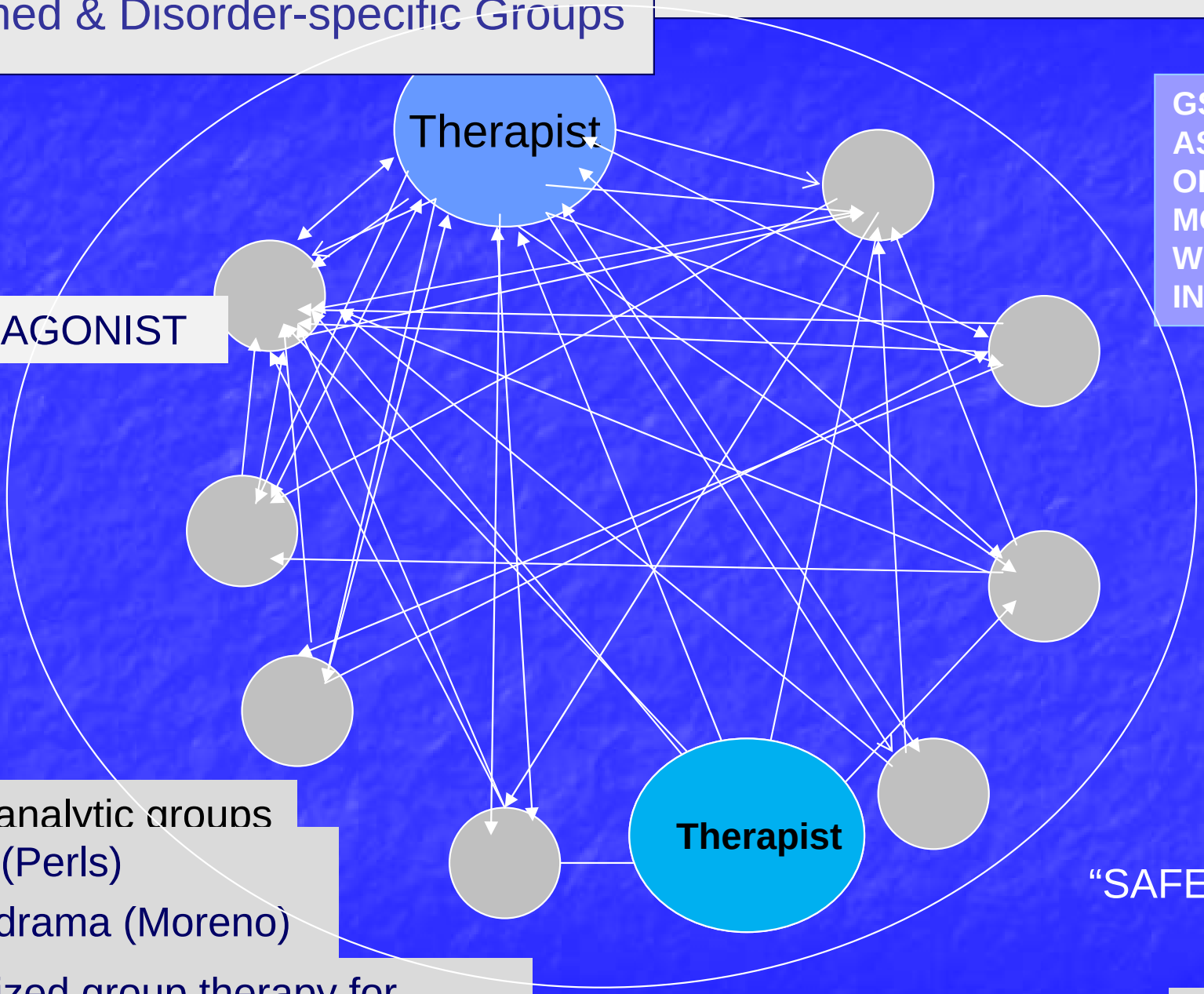
WHICH STRUCTURAL MODEL OF GROUP THERAPY IS GST??

- **Interpersonal or Process group**
- **Person-oriented group**
- **Psychoeducation, Skills, disorder specific group**
- **A new integrative model**

Person-oriented Group

nteraction or Process Groups

Psyched & Disorder-specific Groups



GST INTEGRATES ASPECTS OF OTHER MODELS WITH THERAPIST INVOLVEMENT

PROTAGONIST

Psychoanalytic groups
Gestalt (Perls)
Psychodrama (Moreno)

Manualized group therapy for specific disorders: Depression, Panic Disorder, Social Phobia, etc.

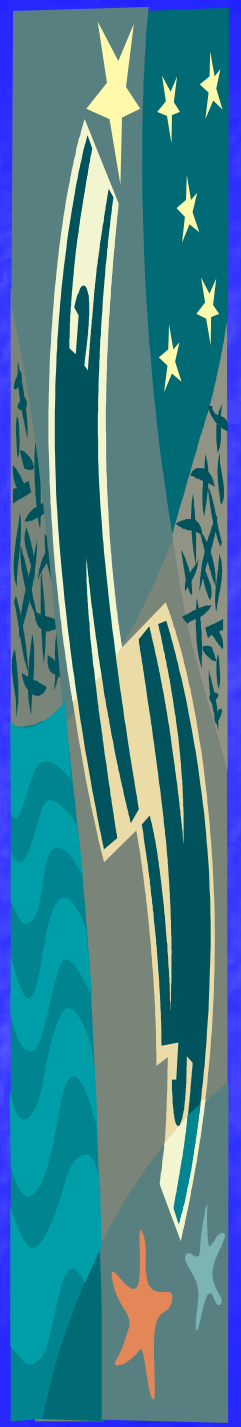
"SAFETY BUBBLE"

Farrell & Shaw
Sipos & Schweiger

THERAPY GROUP S

THE COURSE OF GROUP ST

- Orientation, psychoeducation
- Safety - establish safe group environment
- Bonding– with therapist & group
- Stabilize – life threatening behavior
- Mode Change: Assess: symptoms & their modes
- Get through/around coping modes
- Heal Abandoned-Vulnerable child mode
- Eliminate Punitive/demanding mode
- Channel Angry/Impulsive Child mode
- Autonomy
- Strengthen Healthy Adult mode
- Develop Joyful Happy Child Mode
- Link to Peer Support



MAIN COMPONENTS OF GROUP OR INDIVIDUAL SCHEMA THERAPY ARE THE SAME

1. LIMITED REPARENTING
2. MODE CHANGE – INTEGRATIVE
   - EXPERIENTIAL WORK
     - IMAGERY WORK
     - MODE ROLE PLAYS
   - COGNITIVE
     - TRAUMA PROCESSING
     - REFRAMING
     - ID DISTORTIONS
   - BEHAVIORAL PATTERN BREAKING

HOWEVER, THEY ARE ADAPTED TO THE GROUP MODALITY

ANOTHER DIFFERENCE:

Just as individual ST has phases, the PHASES in the life of a Group – must be recognized & either facilitated or managed

Some similarity to the naturally occurring stages of process groups with more therapist facilitation and limit setting.

GROUP STAGES

- Bonding & Cohesiveness – strong facilitation
- Conflict – management and limit setting
- The Working Group - facilitation
- Autonomy – but “well-connected”

THE FOUNDATION OF ALL SCHEMA THERAPY IS

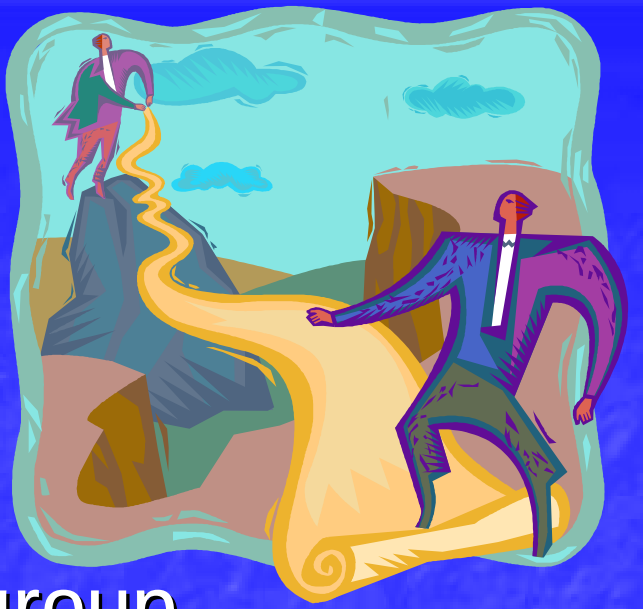
LIMITED REPARENTING*

In Group Schema Therapy, this means building and parenting a safe family.

Ideally, this task is accomplished by two parents – i.e., 2 equal co-therapists

*within appropriate and ethical professional limits and the therapist's comfort & ability

THE COURSE OF GROUP ST: The Beginning



LIMITED REPARENTING

- Bond with individuals and as a group
- Provide stability - Group Groundrules
- Develop Safety
  - Stabilize life threatening behavior
- Guidance - I.D. problems in ST language (Psychoeducation BPD & ST)
- Build a Healthy Family – cohesiveness, bonds among group members

1. LIMITED RE-PARENTING FOR A GROUP

- Build a healthy “family”
- Like ST, secure attachment with therapists
- Meet core needs – in group these can conflict
- Families do best with 2 parents
- Bond with the group as an entity
- Facilitate bonds among members - cohesiveness

THERAPISTS AS GOOD PARENTS PROVIDE STABILITY

By establishing & maintaining:

- Ground-rules
- Predictability
- Reliability
- Consistency
- Engagement
- Confidence
- Supportive structure

SAFETY IS A PRIMARY NEED
Therapists provide it by:

- Being in charge – like a symphony conductor– amplify, quiet or control as needed
- Impart competence & confidence
- Use empathic confrontation & limit setting as a good parent would
- Group support can add safety if a “healthy family” has been created

TWO THERAPISTS ARE NEEDED

We see 2 equal co-therapists as NECESSARY TO MAINTAIN THE EMOTIONAL CONNECTIONS THAT ARE CRITICAL TO ST

The inpatient BPD data supports the importance of two therapists. It may be particularly important for BPD.

THE CO-THERAPIST MODEL OF GROUP SCHEMA THERAPY

Two therapists can attend to different aspects of the group :

- One takes the lead while the other focuses on maintaining connection with the rest of the group
- The therapist not leading can bring the group into the work or shift the focus back to the group

This approach is not like Individual therapy in a group. It accomplishes in a group a crucial foundation aspect of ST – in particular for BPD – maintaining an emotional connection with all patients.

BUILD A HEALTHY "FAMILY" by FACILITATING GROUP COHESIVENESS

- Encourage mutual support
- Require mutual respect
- Point out similarities – in symptoms, problems, developmental history
- Accept differences – all are valued
- Good parents are fair
- Validate members' strengths
- Share emotional experiences
- Develop group memories & language

A "SAFE FAMILY" GROUP CAN PROVIDE

- Added feelings of safety
- More options for positive connections that can extend to "real life"
- A closer analogue to "real life" and the family of origin that facilitates emotional learning

Research is suggesting that Group ST may be the optimal setting for treating people with BPD

THE COURSE OF GROUP ST 2:
MODE CHANGE WORK FOR BPD

- Get through/around Coping modes
- Reach & Heal Vulnerable Child mode
- Eliminate Punitive/Demanding Parent
- Channel Angry Child mode
- Healthy limits for Impulsive Child mode
- Develop Healthy Adult & Happy Joyful Child Modes

GO IN WITH A PLAN – but be ready to change it

- You cannot ignore modes that are present
- “Teachable moments” must be seized
- Often we “weave” back and forth between situation & therapy topic
- Often you end up with a more effective intervention than the plan you started with
- The plan can give therapists security and you can go back to the plan

STABILIZE LIFE-THREATENING SYMPTOMS: Emergency Plan as a "stop-gap" measure

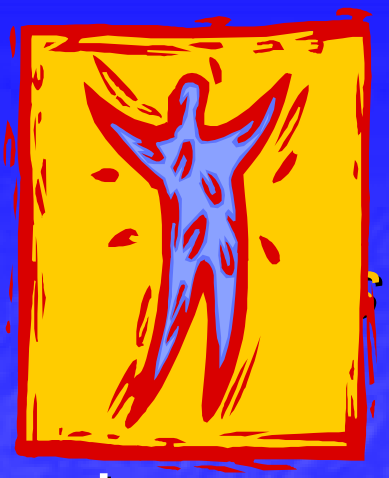
- Identify Modes currently destabilizing or with safety issues
  - Use self-monitoring
- Identify NEED present
- Identify safe way to meet need
- This gives an initial Schema mode management plan – expand over time

MODE CHANGE WORK 1

IDENTIFY MODES AS THEY OCCUR IN THE GROUP

- They can be expert at identification in others
- Use as a foundation for seeing modes in themselves
- “Double asking”
- “What’s my Mode?” game
- Color Game-first feelings, then apply to Modes

EXPERIENTIAL MODE WORK IN GROUP



Group provides a larger frame & more for creative and symbolizing exercises

- The “good family” of group elicits many modes – thus, many opportunities for emotional learning
- More characters for Gestalt work – Full Chairs
- Experiences of belonging, fun, laughter, being silly are available in a wider range
- Other patients can provide a different kind of comfort and support for “scary” Parent mode work
- More intense emotional experiences can be accomplished – e.g. Identity bracelet, group safety blanket, notes for Vulnerable Child

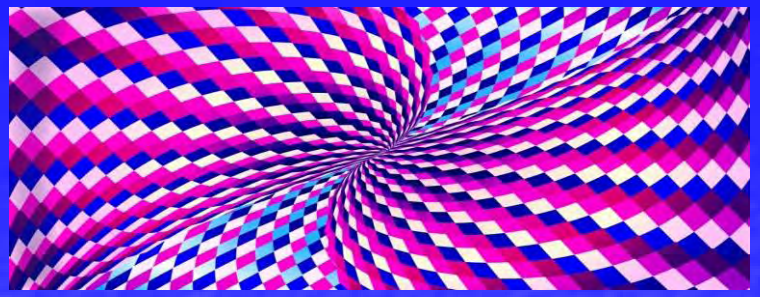
COGNITIVE MODE WORK IN GROUP

More input and ideas are available for:

- Pro & con lists and exercises (e.g. “The Court)
- Ways to reframe the negative interpretation of individual or shared experiences
- Recognizing cognitive distortions
- Remembering positive evidence against schemas or Parent Modes
- Analyzing “Circle” monitoring and recognizing “fact” versus “belief” or Parent voices

Written homework acts as a helpful starting point for the group and another way to connect – shared task

BEHAVIORAL PATTERN-BREAKING IN GROUP



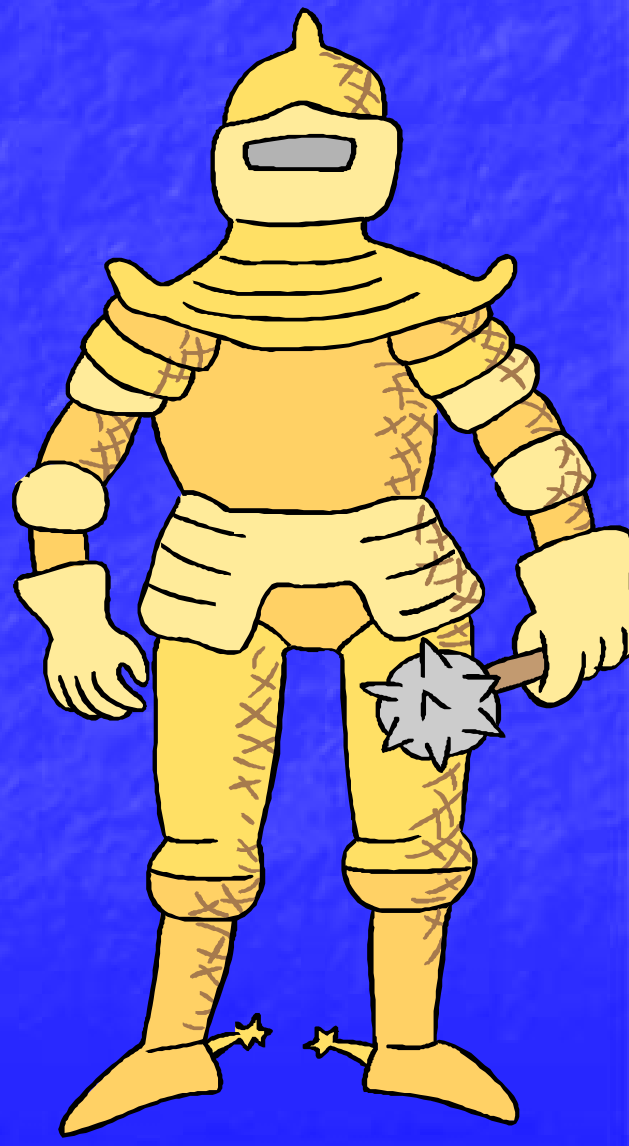
GROUP IS A MICROCOSM OF WORLD – IN-VIVO PRACTICE, VICARIOUS LEARNING, MODELING AND EXTINCTION OPPORTUNITIES ABOUND

Therapists underline new learning and accomplishments and can lead the validating cheers or comforting words of the group. More sources of reinforcement for positive change and pointing out growth.

Highlights:

GET THROUGH COPING MODES

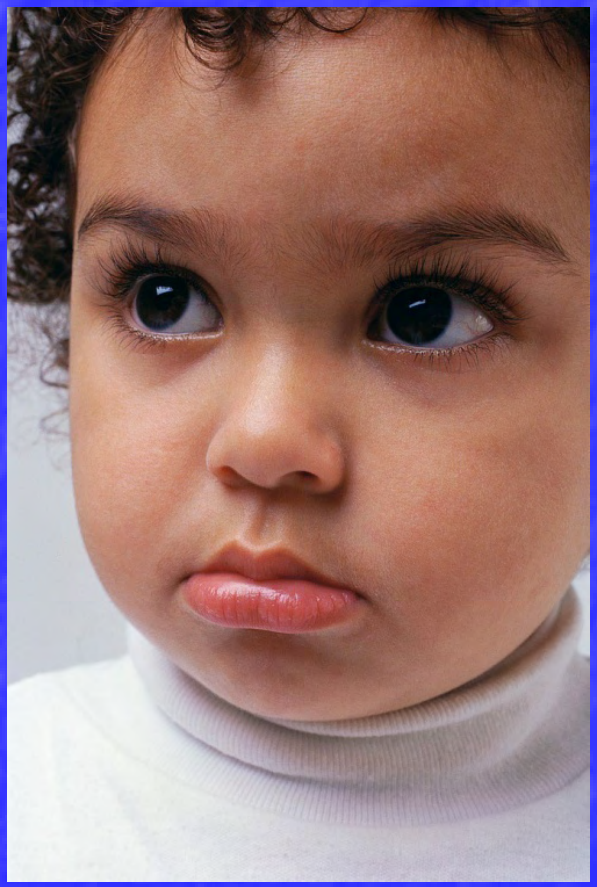
- Experiential Focusing Exercise
- Awareness work – Kinesthetic, Grounding exercises
- Vicarious learning – role plays
- Observing consequences of unhealthy coping in peers
- Empathic confrontation has increased salience when peers confront
- Double Asking technique



Highlights:

VULNERABLE CHILD MODE WORK: Protection & Healing

- Group provides the new experience of belonging
- Opportunities for receiving nurturing & caring from a larger "family unit" group
- Discovery that vulnerability leads to comfort- not punishment
- Imagery re-scripting with group support



GROUP IMAGERY WORK

- Safety Images
- Good Parent Images
- Strengthening Images
  - Link VC with Therapist
  - Link HA with therapist
  - Link VC with HA
- Imagery Re-scripting
  - Individual focus is broadened to the group
  - Whole group re-scripting
  - Move between past and present

GROUP IMAGERY RE-SCRIPTING 1

Begin with Group as a whole, stay with group

1. All stay in their image with vulnerable child
2. Therapist enters image as good parent
3. Provides symbolic safety – e.g., safety bubble around all
4. Banishes Punitive Parent for all
5. Joins the group together
6. Talks about them being in their safe group space
7. Brings them back to the present reality of group safety and support now

GROUP IMAGERY RE-SCRIPTING 2

Begin with Group, go to individual

- VC imagery exercise for the group
- Focus on individual reacting emotionally -identify memory & need of VC
- Therapist 1 rescripts first by providing need, next pulls group into image
- Therapist 2 brings in group with questions about similar experiences
- Therapist 2 facilitates a tangible group connection, Therapist 1 supports VC
- End with focus on the HA strength and supportive presence of the group for all

MODE ROLE PLAY:
Group provides many options

- Good parent for Vulnerable Child
  - Fight the Dysfunctional “Parent” Mode
    - Support the VC doing this comes later
  - Comfort and soothe the frightened VC
    - Self-soothing comes later
- Good Parent for Angry or Impulsive Child
  - Listen and validate
  - Set limits and Guide

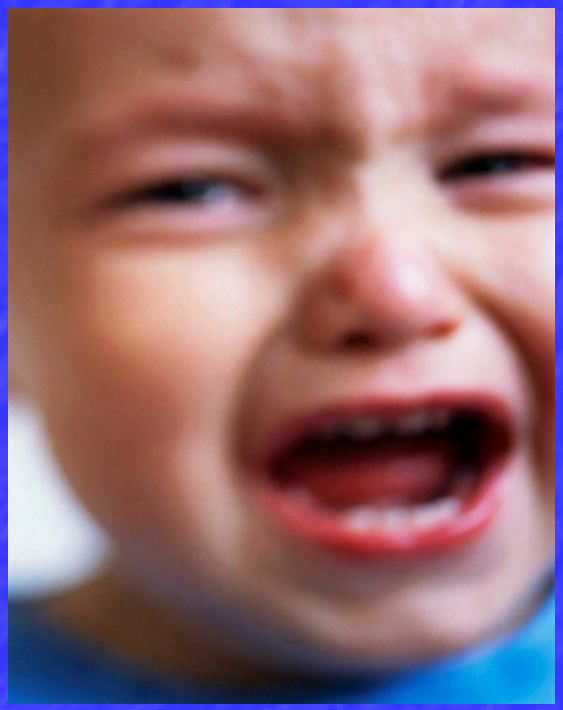
EXPERIENTIAL MODE WORK
THE USE OF SYMBOLS

- Match the emotional development stage of the patient
- Use “Transitional objects” for attachment
- Representations of Vulnerable Child - soft fleece, small doll, etc.
- Representations of “Good Parent” – e.g., group blanket, written cards, teddy bears

Highlights:

ANGRY/ IMPULSIVE CHILD MODE WORK: Contain & Channel

- Containment & limits from therapists & group
- Safety in numbers
- Role play options with “good parent” or peers
  - Assertiveness
  - Negotiation
  - Conflict resolution
- Learning that anger can be positive & channeled safely



Highlights: DYSFUNCTIONAL PARENT MODES: Diminish & Banish

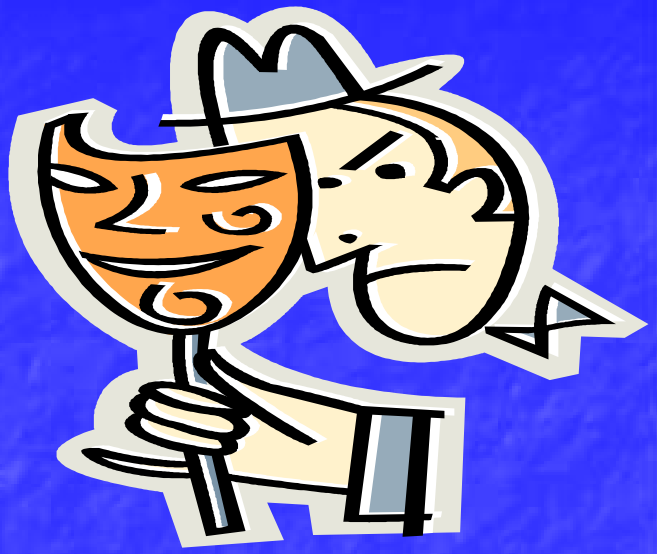
- "Villains" are more clear to others
- Group consensus on what is reasonable vs. punitive
- Group as an army of defenders
- Destroy in effigy
- Role-plays
- Re-script with "Good Parent", later Healthy Adult

"FULL CHAIR" WORK

Group offers many options:

1. Patient observes role play = vicarious learning opportunity
2. Therapists play all roles – with patient as coach
3. Patient plays another mode role – e.g. Punitive Parent
4. Group as an "Army" of protectors for VC
5. Patient plays self as Healthy Adult with or without coaches, supporters

PARENT EFFIGIES – can make role play more real



- Write on a cloth form Punitive Parent messages to get rid of
- Use effigy as a “mask” for peer playing PP
- Demonstrates PP’s lack of power in present
- Therapist takes PP away to lock it up
- Write cards with Good Parent counters to the specific messages identifies

REPLACE WITH GOOD PARENT EFFIGY

Group provides a controlled experience of competence and value -- with therapists there to help assign meaning to the event and the cognitive anchor of a label.

Highlights: HEALTHY ADULT MODE Develop & Strengthen

- Identify strengths & accomplishments
- Support for claiming their voices
- Reinforce competence
- Praise
- Share celebrations
- Peers can reframe “mistakes” effectively
- “Group Identity” stabilizes

STRENGTHEN THE HEALTHY ADULT IDENTITY WORK

Cognitive Work:

- Correct misinformation – faulty labels from family replaced by more accurate ones
- Group provides new “reference points” for self

Experiential work:

- “Seize the moment” when pt demonstrates a strength – record or symbolize it, also in group memory
- Identity/affirmation bracelet to symbolize strengths

Behavioral Pattern Breaking

- Act in group as an effective, competent and valuable to group Healthy Adult with good outcome

ENCOURAGE THE HAPPY, JOYFUL CHILD MODE

- Normal, developmental stage of exploration that is the foundation of identity and "meaning of life" experiences
- Group Play – "Olympics" example
- Shared experiences – Zoo example
- Provides balance for abandoned, abused, vulnerable child modes

GROUP CAN PROVIDE MISSED ADOLESCENT DEVELOPMENTAL EXPERIENCES

- Provides a peer group
- Opportunities to express & work through “rebellious teenager” stages safely
- Normalize sexual feelings
- Opportunities for boundary work with therapist input
- Practice for autonomy
- Opportunities unique to group

GROUP THERAPIST TASKS-
A BALANCING ACT

MAINTAIN BONDS

- Limited re-parenting continues
- Individual & group

MAINTAIN SAFETY

- Be a Good Parent
- Ground-rules
- Limits

MODE CHANGE WORK

- Match the modes that are present
- Deal with crisis situations
- Address homework & task that is planned, but be ready to seize the experiential moment

THE FUTURE OF GROUP SCHEMA THERAPY

- Growing empirical validation for BPD
- Multi-site RCT (14 sites in 5 countries)
- Forensic adaptation
- Exploring adaptation for other PDs & chronic Axis I – anxiety, depression
- Treatment Manual – 2011??
- GSTCRS & ISST Group certification explored

Just as ST developed to more effectively treat PD issues, GST has same potential

TREATMENT OPTIONS - BPD

OUTPATIENT ST FOR BPD: TWO YEARS in 2 FORMATS

	PRIMARILY GROUP	COMBINATION
YEAR 1 – (44 weeks)	2x wk Group, 12 Individual	1x wk Group, 1x wk Individual
YEAR 2- 6 MONTHS	1x wk Group, 3 Individual	1x wk. alternates Grp+Indiv
3 MONTHS	Group biweekly, 1 Indiv	Group biweekly, 3 Indiv
3 MONTHS	Monthly Group session and 1 Individual session	
TOTAL SESSIONS $40/Grp, $100. Indiv.	120 Group, 17 Individual $6,500.	70 Group, 59 Individual $8,700.

INTENSIVE GROUP + INDIVIDUAL ST

	GROUP SESSIONS	INDIVIDUAL SESSIONS
12 WEEKS	114 HOURS	12-18
INPATIENT	$800./DAY = TOTAL $67,200.	
DAY HOSPITAL	$150/DAY = TOTAL $12,600.	

GROUP SCHEMA THERAPY MULTI-SITE RANDOMIZED CONTROLLED TRIAL

- Planning for the Multi-site RCT of our group schema therapy model began at the Coimbra conference.
- Study design – an adequately powered test of group ST in the treatment of BPD
- Total of 14 sites - 2 in USA, 2 in Australia, 6 NL, 3 Germany, 1 in UK 448 subjects

SPECIFIC AIMS

- Evaluate the effectiveness group schema therapy as a comprehensive treatment for BPD.
- Identify predictors of treatment response
- Evaluate cost-effectiveness
- Assess stakeholders opinions

TRAINING IN FARRELL-SHAW MODEL OF GROUP SCHEMA THERAPY

- 100 schema therapists, HAVE COMP0LETED 3 DAYS OF TRAINING,
- OF THOSE, 70 COM0PLETED THE FULL 6 DAY INTRODUCTION
- ISST Committee on Group ST

In conclusion, the all BPD “groups from Hell” became a powerful medium for effectively treating BPD emotional learning deficits and facilitating improved quality of life for this troubled group of patients, and the most creative, positive and supportive groups we have led.

THE SCHEMA THERAPY GROUP CAN BE A PLACE WHERE:

- The Vulnerable Child finds safety, belonging and healing
- The Punitive Parent is banished
- Angry/Impulsive Child/Teen: is transformed into strong and competent Healthy Adult
- The Health Adult develops & the Happy Child finds playmates

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We offer Group Schema Therapy training, supervision and research consultation