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Cognitive therapy and schema therapy in depression

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Schema therapy is one of a number of new therapies arising out of the cognitive behaviour therapy (CBT) modality. Jeff Young builds on "standard" CBT but also draws from a rich tradition of other psychotherapy techniques (Young, Klosko, & Weishaar, 2003). This complex therapy package is designed to assist with complex chronic difficulties, including personality disorders. This therapy has considerable face validity and has been well disseminated and adopted in clinical practice internationally, including in New Zealand. The aims of this paper are to describe CBT (J. S. Beck, 1995) and schema therapy approaches for a composite "typical" depressed client to illustrate similarities and differences. We also present some initial impressions as clinicians delivering both treatments in a research trial.

CBT is the most heavily researched psychotherapy orientation. Large evidenced-based reviews and meta-analyses of treatment for depression show CBT to be superior to no-treatment comparison groups, treatment as usual, supportive psychotherapy, and psychodynamic approaches in achieving increased rates of recovery. CBT appears to be equivalent to interpersonal psychotherapy and, in some studies at least, to have comparable efficacy to antidepressants but to be better at preventing relapse (see reviews: ; A. T. Beck, 2005; Butler, Chapman, Forman, & Beck, 2006; Churchill, 2003). Increasing evidence that depression is a recurring condition and the unacceptable proportion for whom CBT does not help adequately has prompted the continuing search for more effective treatments. There is no published evidence of efficacy of schema therapy for depression although there are research trials underway of schema therapy for substance abuse, personality disorder, depression, and binge eating disorders, the latter two studies being undertaken at the Department of Psychological Medicine, at the Christchurch School of Medicine.

The case - "Anna"

Anna is a 28 year old woman self-referring for therapy for recurrent depression and an exacerbation of longstanding anxiety symptoms. Anna described an unhappy childhood due to her father's alcohol problems and his unpredictable emotional and physical abuse towards her mother. Anna was close to her mother (who also experienced anxiety and low mood) but dreaded her father's rages. She did well at school socially and academically. She opened a successful craft store in her early 20s. She married Dan within 3 months of their meeting and became pregnant immediately, giving up her business to focus on family life. Anna became depressed after the birth of her first child, having trouble adjusting to her new life, and again four years ago, related to marital tension. Dan was often irritable and critical. He worked long hours and played sport, taking little responsibility around the home. Anna tended to bottle up anger but said "I can't leave - marriage is for life. Anyway, he is never violent and he is a good father to the kids". Anna had gradually lost touch with friends.

Cognitive behaviour therapy

A CBT formulation was developed. Childhood predisposing factors included perfectionism, a maternal history of mood and anxiety, an unpredictable abusive early environment leading to learned helplessness and witnessing her mother being abused but minimising this. Predisposing factors in adulthood included a critical, emotionally unavailable husband, social isolation, and loss of a previous successful work role. Anna internalized Dan's criticism, believing she was incompetent. Her beliefs about marriage kept her in the relationship. Triggering events included a role change and a deteriorating marital relationship after the birth of her first child.

Maintaining factors included ongoing criticism from her husband, limited coping resources, communication deficits, limited social support, and few positive events in her life.

The first phase of therapy focussed on establishing initial behavioural change. Session 1 included psycho-education about the CBT model of depression and how CBT works (active collaboration, homework), and goal setting. Relevant homework was set, including activity scheduling and self-monitoring. Anna's goals were to feel calmer, happier, less irritable, to improve sleep, improve relationships with her husband, friends, and family (increase social contact, assertiveness), to get on with life (get a part-time job, more interests), and to enjoy life more. The structure of sessions was established with agenda setting, and review of homework tasks (e.g. pleasurable and mastery activities and increasing social support). Relaxation, slow breathing, and sleep hygiene strategies were used to assist with symptom relief. In Phase II, the cognitive module was introduced with education about negative automatic thoughts ("I've stuffed up again…It's all down to me…I should be able to cope…"), and how to challenge these. Cognitive skills were consolidated and behavioural changes maintained during this phase. Anna's perfectionism meant that she was very conscientious with homework, so therapy progressed quickly. She embraced the cognitive model, evaluating her thoughts and changing her negative cognitive biases to more realistic and helpful appraisals. Assertiveness skills were helpful for relationship issues, and problem solving strategies were used to assist her in deciding options for jobs and life goals.

Phase III tasks included preparing for the end of treatment — reviewing progress with goals and how to address outstanding issues, anticipating future stressors, and developing an individualized relapse prevention plan. Anna reported that she was happier, sleeping well, and relating better to her husband, friends, and family. She was more confident and assertive, enjoying a new part-time job, and generally felt more in control of her life.

Schema therapy

A schema formulation was developed using information from a clinical interview, schema questionnaires, assessment imagery, and discussion with Anna. On the *Young Schema Questionnaire,* Anna scored highly on three of eighteen maladaptive schemas: Self Sacrifice, Unrelenting Standards, and Punitiveness.

Anna's temperament may have predisposed her to certain schema. For example, her quiet nature may have made her more inclined to adopt a self-sacrificing schema rather than an abusive and aggressive response to her father. Anna's schema (comprising memories, body sensations, and emotions) were hypothesised to result from unmet childhood needs, particularly the lack of protection and nurturance, and the requirement that she overlook her own needs to keep the peace. Assessment imagery enriched the information Anna gave on assessment. Imagery included recollections of witnessing abuse that her mother seemed powerless to prevent, and self-sacrificing efforts to get things right in an often futile attempt to avoid her father's rage. Imagery also identified an Emotional Deprivation schema that Anna had not been aware of. It was difficult for Anna to recognise the absence of nurturing in her life, however it had a significant impact on her and played a central role in her cluster of schemas.

Anna's schemas were maintained by several mechanisms, including cognitive distortions (e.g. black and white thinking about her performance) and self-defeating life patterns (e.g. choosing a critical partner). They also included schema coping styles and responses such as surrendering (e.g. overworking in response to Unrelenting Standards), avoidance (e.g. avoiding negotiating household issues with Dan), and overcompensation (e.g. doing too much for others while neglecting her own needs). Clinical depression may have been a trigger for, or a consequence of the schema operating. During the course of therapy Anna manifested characteristic schema modes such as Vulnerable Child (Little Anna), Punitive Parent, Angry Child (Raging Anna), Detached Protector (Switched-Off Anna), Critical Perfectionist, and People Pleaser.

Simplifying a complex schema formulation with these user-friendly metaphors made therapy more straight-forward for therapist and client.
The first two treatment sessions focused on activating Anna's Healthy Adult mode, encouraging activity and pleasant event scheduling in order to elicit a shift in depressive symptoms. Middle sessions used a variety of experiential, cognitive, and interpersonal techniques with imagery and role play of schema modes predominating. During later treatment sessions Anna was actively encouraged and challenged to make significant changes in order to fight the schema and strengthen Healthy Adult behaviours.

Anna experienced a gradual lift in depressive symptoms, feeling a little better during scheduled pleasant events and experiencing "something shifting" following key imagery exercises. This was followed by changes in the way she related to Dan (becoming more assertive and refusing to take his critical comments personally). She became more self-reflective and reported choosing to act from a Healthy Adult mode rather than one of her Child modes in several difficult situations. This resulted in some improvement in the quality of her relationship with Dan, with an awareness that problems in that relationship may need further work in the future. Anna was clearer about her needs and found appropriate ways to meet those needs, including taking regular time out to follow her interest in handcrafts and spending time with supportive friends.

Discussion

As noted earlier, schema therapy has arisen from within standard CBT but incorporates many CBT concepts and strategies within a broader integrative model along with other techniques and concepts from modalities outside CBT. Table 1 summarises similarities and differences between these two therapies. Although there is a great deal of overlap with CBT, key differences in schema therapy are the greater emphasis on full expression (rather than control) of affect (especially anger), experiential techniques to elicit affect, the therapeutic relationship, childhood origins of schemas, coping styles, and core schema.

Table 1: Comparison of cognitive therapy (Beck) and schema therapy (Young)

	Cognitive therapy	Schema therapy
Goals	Assist client to overcome (control) emotional problems by monitoring and changing thinking	Help client get core needs met in an adaptive manner through changing maladaptive schemas, coping styles, responses and modes
Schema	Central cognitive structures within the mind, the specific content of which are "core beliefs". Comprised of cognitions	Extremely stable and enduring patterns. Comprised of memories, bodily sensations, emotions and cognitions
Number of schema	Three broad categories: Helplessness Inadequacy Unlovability	Eighteen specific schema
Behaviour	Coping strategies acknowledged	Coping styles central: Surrender Overcompensation Avoidance
Modes	Intense psychological reaction	Shifting patterns of activation and deactivation. Specifically worked on with range of strategies
Overall strategy	Top down	Bottom up
Structure	Formal agenda, structured	Informal agenda, limited structure
Problem focus	Present/current problems	Lifelong problems
Therapy focus	Automatic thoughts	Schemas, coping styles, modes
Therapist style	Active, collaborative, empiricism	Active, empathic confrontation
Therapist-client relationship	Primary way to motivate. Focus on only if impeding therapy	One of four equal therapy components. Limited re-parenting.
Identification of schema	Through negative automatic thoughts and themes	Variety of specific tools
Childhood experiences	Not a specific focus of therapy	Specific focus of therapy
Strategies	Education Cognitive Behavioural Experiential (limited) Shared case conceptualization Homework	Education Cognitive Behavioural Interpersonal Experiential (extensive) Shared case conceptualization Homework

	Cognitive therapy	Schema therapy
Length of treatment	Short term	Longer term

After Carter (2005).

As therapists using both therapies within randomised controlled trials, our experience and clinical impressions are that schema therapy feels very different from CBT. CBT is more familiar and straightforward, offering greater structure and coherence. With CBT, clients who embrace the CBT model appear to do well while others who dislike or struggle with aspects of CBT may require modification of the usual presentation to assist them in utilising therapy.

Schema therapy is less structured, more flexible and creative, and the imagery takes us into the unknown in a way that standard CBT does not usually do. The more central role of affect creates greater depth in the therapeutic relationship, which may be more challenging for therapists. Schema formulation is more complex than CBT formulation. We have used modes conceptualization more frequently than expected – modes is an economic way of making sense of client history and functioning with the complex schema model, explaining how various schemas and coping strategies inter-relate and play out differently within each mode. Clients who embrace the schema model appear to derive considerable benefit and make significant changes intra- and interpersonally. Others, particularly those who usually avoid affect, may find imagery difficult or uncomfortable, and we have had to find more concrete or perhaps less intense ways of working with these clients to implement schema principles. Many questions still arise in the application of schema therapy principles and our supervision group has been invaluable in helping us develop ways of adapting or extending schema therapy for particular clients.

Conclusions

Schema therapy is an interesting "new" therapy with face validity and widespread clinical adoption but with little empirical basis as yet. As therapists we can see advantages and challenges in CBT and schema therapy for particular clients. Delivering both therapies within the constraints of a research trial is a challenging and stimulating endeavour. Research trials comparing schema therapy and CBT are underway but it will be several years before data are available about the relative efficacy of these two therapies and whether the theoretical departures of schema therapy from CBT and therapist anecdotal impressions of differences are present and detectable.

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