Augmenting the Treatment of Co-Occurring Substance and Mental Health Disorders with Schema Assessment and Therapy

Chad T. Wetterneck, PhD

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ROGERS Behavioral Health

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Disclosures

The presenter has declared that he does not, nor does his family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation. The presenter has declared that he does not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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Disclaimer

- Many of the examples may consists of trauma-related concerns and may elicit uncomfortable feelings

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Learning Objectives

1. Describe how early maladaptive schemas develop and how to explain then to a patient in a validating manner
2. How to assess for early maladaptive schemas
3. Formulate and carry out a plan to include schema therapy techniques to support individual, group, and family work

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Our co-occurring patients at Rogers Behavioral Health

- Mostly comorbid with mental health conditions
  - Frequently depression and mood disorders, PTSD, eating disorders, other anxiety disorders, and personality disorders
  - Trauma and depression are the most frequent
- Average length of stay
  - 4-5 weeks in residential
  - 4 weeks in partial hospitalization (PHP)
  - 3-4 weeks in intensive outpatient (IOP)
- Frequent assessment of symptoms and relevant treatment constructs

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Trauma-related factors influencing outcome

Pretreatment variables

- Trauma-related
  - History of childhood trauma
  - Multiple traumas
  - Personal vs. impersonal trauma
  - Time since trauma
  - Whether injured during trauma
- Personal characteristics
  - Suicidal

Rogers residential patients

- Trauma-related
  - Most patients endorse trauma history
  - Most have trauma from childhood/adolescence
  - Most have multiple traumas
  - We are treating them years or decades after traumas occurred
  - Approximately 25% are receiving evidence-based PTSD treatment

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Admission assessments

Structured Clinical Interviews (when appropriate)

- MINI – 20+ Common Diagnoses
- CAPS – In-depth PTSD history and severity
- UConN Racial-Ethnic Stress and Trauma Scale (UNRESTS; Williams et al., 2018)

Self-Report Assessing Relevant Constructs

- Self-Compassion, Valued Living, Engagement in Behavioral Activation, Dimensional Ratings of Symptom Severity
- Early Maladaptive Schemas

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Trauma treatment principles at RBH

Program principles

- Program focuses on symptom reduction and on defining and pursuing meaning/values in life
- Principles driven program with a focus on SUD psychoeducation, behavioral activation, exposure, values identification and pursuit, self-compassion, interpersonal intimacy, and mindfulness
  - Helping with the skills to be in touch with their emotions and able to connect with others in a healthy manner
    - Very important for sustained recovery

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Trauma-informed care

- Aims to avoid re-victimization
- Appreciates many problem behaviors began as understandable attempts to cope
- Strives to maximize choices for the survivor and control over the healing process
- Seeks to be culturally competent
- Understands each survivor in the context of life experiences and cultural background

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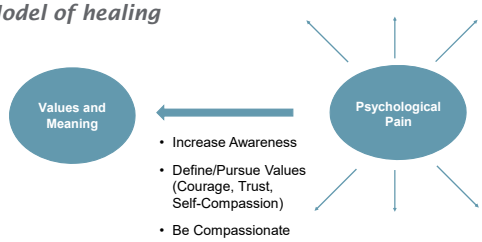
Model of healing



- Increase Awareness
- Define/Pursue Values (Courage, Trust, Self-Compassion)
- Be Compassionate

(Wetterneck et al., 2017)

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Evidence-based treatment….

- Prolonged exposure (PE) for PTSD
- Behavioral activation (BA) for depression
- Exposure therapy for anxiety and eating disorders
  - Interoceptive exposures for panic
- Exposure and response prevention for OCD
- Dialectical behavior therapy (DBT) skills groups

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….augmented by contextual behavioral science

- Elements of acceptance and commitment therapy (ACT)
  - Touching on all elements of the hex-a-flex
- Principles of functional analytical psychotherapy (FAP)
  - In both individual and group work
- Dialectical behavior therapy
  - Typically individual taught
  - DBT is integrated into the trauma narratives in PE
- Schema therapy
  - Self as context exercises, exposures, integration in trauma narratives

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Interpersonal and Intrapersonal problems in trauma

Extremes of emotions
- Emotional numbing
- Dysregulation

Feeling cutoff from others

Avoidance of closeness
- Avoidance of interpersonal situations and actions in these situations that keep others at a distance

Feelings of foreshortened future

Shame-based behaviors

Bistricky, Gallagher, Roberts, Ferris, Gonzalez, & Wetterneck, (2017)

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Critique of the PE model

- Top evidence-based treatment for PTSD (APA, 2018)
- Most inclusive based on ethno-racial background (Kusch Grau, Warner, Loyo, Zhang, Williams, & Wetterneck, 2019)
- Likely returns client to near pre-trauma functioning
- Trust and healthy therapeutic relationship required
- What happens when….
  - Client does not have healthy pre-trauma functioning in interpersonal relationships and experiencing emotions?
  - Lacks experience with trust, has poor insight or low self-efficacy?

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Critique of the PE model (cont.)

- Dropouts are still an issue
- Not everyone responds to treatment
- Long-term abuse starting earlier in life greatly interrupts development of social, emotional, and psychological functioning
- New diagnosis proposed: Complex PTSD
  - Symptoms between Borderline Personality Disorder and PTSD
- Does not address adverse childhood experiences (other than perhaps trauma) or family involvement

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Adverse childhood experiences (ACEs)

- Verbal, physical, or sexual abuse
- No familial support or basic food/hygiene needs met
- Divorce, death or abandonment by a primary caretaker
- Abuse of a primary caretaker
- Live with a substance user, someone with a mental illness, or primary caretaker who went to prison

Felitti et al., (1998)

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Consequences of ACEs

Increase risk of:

- Early smoking, substance use, and substance abuse issues
- Low health related quality of life
- Disease (COPD, IHD, liver, lung cancer, etc.)
- Depression, suicide attempts
- Early sexual experiences, more sexual partners, and more STIs
- Risk for intimate partner violence
- Adolescent pregnancy, unwanted pregnancy, and fetal death

Felitti et al., (1998)

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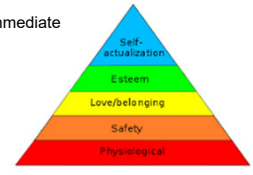
Consequences of ACEs (cont.)

- It takes resilience to survive
- Children and adolescents solve immediate problems with whatever behavior they believe will work
- Short-term survival may begin a pattern of long-term dysfunction
- Every current problem was previously a solution



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Consequences of ACEs (cont.)

Interference in

- Identity
- Self-Direction
- Empathy
- Intimacy

APA (2013)

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Connecting ACEs with schema theory

Patients with ACEs have difficulties with:

- Compliance
- Access to cognitions and emotions
  - Poor insight or more sophisticated defenses?
- Psychological flexibility
  - Thoughts and behaviors may be ego-syntonic
- Developing a healthy therapeutic alliance
- Easily identifiable targets for treatment

(Young et al., 2003)

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Development of schema theory

- To help with treatment "failures" from CBT
- *Schema* – an abstract cognitive plan that serves as a guide for interpreting info and solving problems:
  - A broad, pervasive pattern or theme
  - Comprised of memories, emotions, cognitions, and bodily sensations
  - Regarding oneself and one's relationship to others
  - Developed during childhood or adolescence
  - Elaborated throughout one's lifetime and
  - Dysfunctional to a significant degree

(Young et al., 2003)

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Development of early maladaptive schemas (EMSs)

Develop from unmet core emotional needs

- Secure attachment to others
- Autonomy, competence, and sense of identity
- Freedom to express valid needs and emotions
- Spontaneity and play
- Realistic limits and self-control

Fostered by four main types of situations

- Frustration of needs (not enough of a good thing)
- Traumatization or victimization
- Too much of a good thing
- Selective internalization or identification with sig.

Interact with temperament

(Young et al., 2003)

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Schema domains

Disconnection and Rejection – needs are not met for safety, love; poor attachment

- Family of origin likely to be detached, cold, rejecting, withholding, abusive, etc.
  - Abandonment/instability
  - Mistrust/abuse
  - Emotional deprivation
  - Defectiveness/shame
  - Social isolation/alienation

(Young et al., 2003)

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Schema domains (cont.)

Impaired Autonomy and Performance – poor expectations about perceived ability to function independently and successfully

- Family of origin likely to enmeshed, overprotective or non-reinforcing
  - Dependence/Incompetence
  - Vulnerability to harm or illness
  - Enmeshment/underdeveloped self
  - Failure

(Young et al., 2003)

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Schema domains (cont.)

Impaired Limits – deficiency in internal limits, responsibility to others, or long-term goal orientation

- Family of origin likely to be permissive, overindulgent, lack of direction, or sense of superiority
  - Entitlement/grandiosity
  - Insufficient self-control / self-discipline

(Young et al., 2003)

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Schema domains (cont.)

Other directedness – excessive focus on others at the expense of one's own needs

- Family of origin likely to have conditional acceptance
  - Subjugation
  - Self-sacrifice
  - Approval-seeking/Recognition-seeking

(Young et al., 2003)

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Schema domains (cont.)

Overvigilance and Inhibition – excessive emphasis on suppressing one's spontaneous experiences or meeting rigid, internalized rules at the expense of quality of life

- Family of origin is demanding, perfectionistic, and maybe punitive
  - Negativity / pessimism
  - Emotional inhibition
  - Unrelenting standards / Hypercriticalness
  - Self-Punitiveness

(Young et al., 2003)

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Research on schemas and trauma

Most research involves trauma-related schemas

- Negative views about the world
- Negative cognitions about the self
- Self-blame

What about early maladaptive schemas?

- Little research on EMS in PTSD or SUDs
- Is the measure reliable?
- How does it relate to symptoms and quality of life?
- Does it add anything beyond trauma-related schemas?

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Current research from RUM-PTSD

Tested 18 EMS on the Young Schema Questionnaire

- All had adequate reliability

Many significant relationships between PTSD severity and quality of life

- Clinically elevated EMS

Using step-wise regression models w/ trauma-related schemas (1st step) and EMS (2nd step)

- Symptom severity – 40%; 13% unique to EMS
- Quality of life – 44%; 20% unique to EMS

(Wetterneck, 2017)

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Integrating Treatment of Early Maladaptive Schemas into Your Practice

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Interpersonal and emotion schemas

Young Schema Questionnaire – III

- Assesses early maladaptive schemas
- Common elevations in PTSD
  - Abandonment, Mistrust, Self-Sacrifice, Emotion Deprivation, Social Isolation, Unrelenting Standards, Pessimism/Worry, Defectiveness/Unlovability
- Common elevations in Substance Use Disorders
  - Mistrust, Emotional Deprivation, Defective/Unlovability, Insufficient Discipline/Lack of Self-Control, Entitlement

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Schema goals

Explain purpose of assessing schemas

- Opportunity to validate past coping skills
- Increase psychological awareness
- Increase conscious control over schemas
- Weaken memories, emotions, bodily sensations, cognitions, and behaviors associated with them

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Schema assessment

Help patient understand importance of assessment

- Ask them to come up with a few questions they would like answered about interpersonal relationships or intrapersonal experiences
  - Builds investment in the assessment process
- Help shape the question to match measures
- Emphasis openness and honesty
  - Discourage over-endorsement

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Feedback from schema assessment

- Patient reads "patient's guide to schemas"
- Use results to answer patient's questions
- Ask patient for feedback on feedback
  - Explore both agreement and disagreement
- Scoring
  - Explore elevations - clinical (5+) and relative to person and program
  - Pay attention to individual items
  - What situations do people experience thoughts and how do they typically react?

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Common Reactions to Schema Beliefs

- Patterns of behavioral responses include
  - Avoidance
  - Overcompensation
  - Surrendering
- Client may respond with any of the above responses based on context and learning history
- Example #1: Emotional Inhibition - A = Avoids situations/topics with feelings; O = Awkwardly engages but feels forced and unnatural; S = Maintains calm, flat demeanor)
- Example #2: Defectiveness/Unlovability – A = Avoids relationships; O = Attempts to be the perfect partner/friend/colleague etc. out of fear; S = Enters relationships that are unlikely to provide love or support and accepts it

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Principles of the mind – Why do I do what I do?

- The function of the mind is to *survive* and *thrive*
  - Follows rules
  - Processes rapidly after learning a specific task
  - Works on autopilot
- We attend to short-term contingencies over long-term
- The mind chooses certainty over uncertainty (known pain over unknown anything)

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Treatment goals related to schemas

Change self as content to self as context

- Increase awareness through mindfulness and understanding the function of one's behavior
- Choose behaviors different than what your mind suggests – align more with new behaviors in the service of values
- Check with your experience to determine what is most functional for you
- Introduce new learning experiences and new thought patterns

From this day forward you can start being who you want to be rather than what your thoughts and feelings tell you that you are.

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Exposure model of therapy

- Most PTSD, anxiety, and eating disorder symptoms are targeted through exposure methods
  - Separate hierarchies for each area of difficulty
  - Clients assigned a number of *in vivo* exposures for PTSD
- Interpersonal processing involves shaping behaviors in genuine relationships and settings
  - We can build a road map of what that could look like
    - For ease of both patient and staff
  - Shaped by values chosen by patient, broad areas of need, and specific behaviors

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Choosing schemas or items

- Usually start with main elevations on schemas
  - May also work with specific items
- Ask how schema dictates the way they lead their life
  - How does feeling unlovable and wanting to hide your defectiveness from others influence your life in the areas important to you
  - Will reveal ways in which they hide or avoid or overcompensate for their beliefs
  - Design exposures, use Opposite Action, relate action to Values to change behavior

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Example of Treatment Planning from YSQ

Clinician Tasks

- Pick highly endorsed item/area
- Ask how this affects their current areas of functioning
- What does this look like in everyday life?
- Develop a hierarchy of items to challenge these beliefs and change patterns of behaviors

Client Responses

- No one could love me if they saw my flaws
- I don't share anything personal; I avoid relationships
- Superficial conversations; never sharing thoughts, feelings, hopes, dreams, wants
- Client participates in rating items and agreeing to challenge low level items first

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Sample ranking of hierarchy – Emotional Inhibiton

"I control myself so much that people think I am unemotional or unfeeling/uncaring."

7 – Tell trauma narrative to significant other with emotion

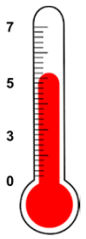
5 – Offer support to someone with emotional distress in the group

4 – Reflect on other's emotions during group

3 – Ask for need to be met in group

2 – Inquire about staff's emotional states

1 – Name own physiological state when asked



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Ask group members about feelings

Ask for need to be met in group

Express fear or sadness in group

Use emotion words in trauma narrative

Using emotion words with therapist when evoked

Display feelings in group

Show feelings during trauma narrative

Offer support to someone in emotional distress in group

Infer feelings of staff

Name his/her physiological state

Comfort significant other while emotional

Discuss frustration with therapist

Reflect on other's emotions in group

Listen to emotional story from significant other

Allow tears in eyes with therapist

Ask peer how they feel

Ask therapist how s/he feels about him/her

Inquire about staff's emotions

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Self-As-Context exercise (ACE narrative)

- Looks similar to a trauma narrative
- Revisiting earlier versions of the patient's life
  - Understanding what was needed in the moment and how that impacts current behaviors
  - It is possible that based on your experiences that you are looking for or acting on needs of your past self, which is part of your current self….
  - Recall first time client had a belief related to elevated item/domain
    - Close eyes, recall event as if it is happening right now
    - Therapist or client enters narrative to ***ascertain needs AND meets them***
- Helps address part of the "Whys" even though it might not be needed for CBT; helps generalize to current day when a schema is activated

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Cognitive strategies

Select core belief

- Based on agreement with client via feedback
- Based on wanting to change aspect of life affect by schema/belief
- Based on your knowledge of available evidence

Set an alliance to work together to be mindful of the schema

- You are the guide to promote acceptance and non-judgment of "the old way/well-worn path."
- May require acceptance strategies as well

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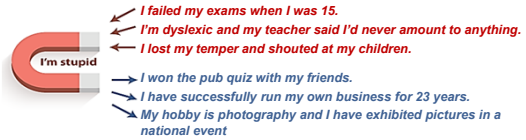
Cognitive strategies: Core beliefs

- Core beliefs are like magnets – they are always waiting to ***attract*** evidence. The more evidence they collect, the stronger they get. Unfortunately, they ***repel*** anything which does not "fit" the belief. This makes is hard to 'see' or believe anything which would contradict or undermine them.



- Core beliefs are not facts – with persistence they an be altered.

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Cognitive strategies: Schema biases

Our core beliefs (schemas) are stable and resistant to change.

- They remain stable by influencing the way we see the work – often through bias or prejudice.
  - Information that does not "fit" with the schema goes unseen, or is distorted or rejected.
  - Information that does "fit" is accepted and can make the schema stronger.

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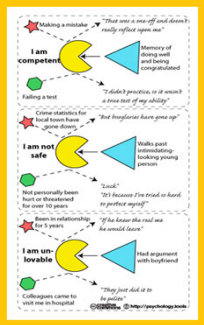
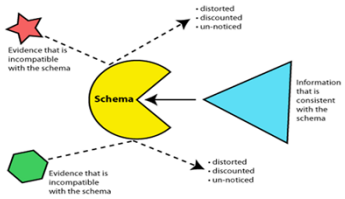


Schema biases



(http://www.psychologytools.com)

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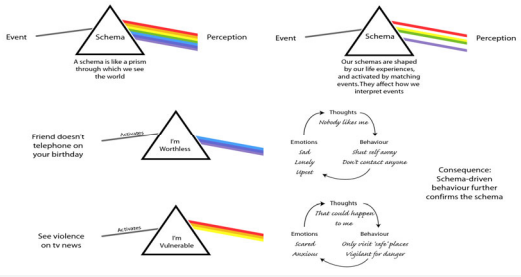
Schema activation formulation



(http://www.psychologytools.com)

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Modifying rules and assumptions

- What is the rule (or assumption) I live by and would like to modify?
- How does this rule (or assumption) affect me in my day to day life?
- What are the origins of this rule (or assumption)?
  - Where did I learn it?
  - What was going on in my earlier life that meant this may have been a helpful rule at that time?
- What are the *advantages* of this rule (or assumption)?
- What are the *disadvantages* of this rule (or assumption)?

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What does acceptance look like?

- Accepting "what is does not mean passive resignation; it is a courageous engagement with the reality of our experience."

  ~ True Refuge, Tara Brach
- Leaning into one's pain and discomfort
- It's not believing you are broken; it's that you have thoughts of being broken and shame that accompanies it

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What are we asking them to accept?

- Pain, fear, other experiences of negative affect
- Dissociative and some psychotic experiences
- You have choices in the present

"What is true is already so.
Owning up to it doesn't make it worse.
Not being open about it doesn't make it go away.
And because it's true, it is what is there to be interacted with.
Anything untrue isn't there to be lived.
People can stand what is true,
for they are already enduring it."

~ Eugene Gendli

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Targeting intimacy and compassion

- Primarily accomplished with interpersonal behavioral (FAP) techniques
- Verbal informed consent for authentic feedback
- Interpersonal groups
  - Setting goals for each group member based on self-reports, therapist, family, and peer feedback and patient's values
  - Teaching the group how to create safety and authentically reinforce others (and themselves) and accept reinforcement from others (and themselves)
  - Journaling
  - Shaping process

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Values assessment

Values – concepts you consider as important regardless of what others think; YOU choose them

- They do not depend on external reinforcement
- You don't need prior experience with them
- Some may be in opposition to PTSD-related behaviors (courage, self-compassion, trust, etc.)

- You choose to strive for; you can never "obtain" them
  - Actions move you toward a value; it's a choice to continue
  - Choose moving toward a value even if nobody noticed
- Identify values in various life domain areas
  - Relationships, Personal Care, Work, Cultural/Spiritual

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Values assessment (cont.)

- In addition to values exploration, we suggest certain values as possible fits
  - Trusting, courage, grit
  - Compassion (to self, to others, receiving from others)
  - Connecting, pride, openness to experience
- We are willing to risk the pliance issues
- We try to define most actions in terms of values
  - E.g., Avoidance = Protecting
- How are they nurturing their garden of values?

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Record risks taken during the day

- Identify type and level of risk (courage) needed
- Values label – what was this in the service of?
- Compassion out / Compassion in
  - What caring statement could you say about someone who accomplished these behaviors?
  - Can you allow yourself to be feel deserving or proud for your efforts?
- Questions may vary based on improving targets of awareness of self/others, courage, and love / self-love

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How much can change can occur?

About this much: →

Example emotional engagement and compassion

Dysfunctional.....**Functional**

- Unaware or unwilling to engage in emotions; no engagement in any type of compassion
- Acknowledgement of own feelings; recognition of concept of compassion
- Acknowledgement of feelings of self and others; accepting of functional value of compassion; no steps toward compassion
- Acknowledgement of emotions in self and others; willingness to try aspects of compassion
- Consistent recognition of and functional engagements of emotions in self and others; compassion practice (typically giving to others at the start)
- Generally aware and willing to engage in emotions in emotions of self and others; demonstrates ability to give compassion to self and others and receive compassion
- Full awareness and engagement of emotions in self and others; able to give self and others compassion and receive it from others

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Typical schema presentations in SUD and trauma

- Always in control
- I am here on this earth for others
- Avoid everything
- Boundaries, where are the boundaries?!?
- Accepting the dysfunctional

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Always in control

- ***Schemas:*** Unrelenting standards; Emotional inhibition
- ***Behaviors:*** Trying to perfect behaviors of themselves and others; No emotional engagement or recognition of own emotions
- ***How others misinterpret:*** May appear hard-working, calm, unfazed by problems; appears busy rather than dysfunctional
- ***Barriers to change:*** Appear functional; can be successful; often uses other dysfunctional coping skills to suppress emotions and/or to sleep (e.g., substance use)

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I am here on this earth for others

- ***Schemas:*** Self-sacrifice; Subjugation; Enmeshed
- ***Behaviors:*** Always doing things for others at expense of one's self; absence of doing anything on their own
- ***How others misinterpret:*** Appears nice, generous, overly compliant; no distress reported
- ***Barriers to change:*** Usually attracts those who are self-centered and not wanting patient to change or grow; helping values are perceived as a value and a choice

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Avoid everything

- ***Schemas:*** Mistrust, Emotional deprivation; Negativity; Vulnerability to harm; Defectiveness / Shame
- ***Behaviors:*** Keeps to self physically and emotionally
- ***How others misinterpret:*** Appears shy or not interested in relationships; does not express needs so appears to have few needs
- ***Barriers to change:*** Appears functional to staying safe; may hang with others unlikely to meet patient's needs

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Boundaries, where are the boundaries?!?

- ***Schemas:*** Abandonment; Approval / Recognition-Seeking
- ***Behaviors:*** Frequent fast-developing relationships, increased sexual activity
- ***How others misinterpret:*** Simply promiscuous (which adds shame); borderline and not PTSD/trauma
- ***Barriers to change:*** Confusion distinguishing between love and sex; shame associated with physical intimacy

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Accepting the dysfunctional

- ***Schemas:*** Failure; Incompetence / Dependence
- ***Behaviors:*** Chooses behaviors to maintain status quo (even when that means no joy and high-stress environments)
- ***How others misinterpret:*** Lazy, unmotivated, pre-contemplative
- ***Barriers to change:*** Uncertainty of change increases fear; poor family support due to misinterpretation

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Cultural diversity and schemas

Patients develop world-view from their identity

- Cultural identity
- Identify areas of strengths
  - Be understanding and demonstrate humility with area you do not understand
  - Goal is to understand what is functional or not in the context of culture

Recognizing the impact of negative cultural experiences

- Experiences with racism, sexism, discrimination, prejudice, etc.
- Stage of Racial identity
- Acculturation
- All of these experiences and attitudes affect intrapersonal emotional functioning and interpersonal relationships

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Involving the family or other support

- Identifying possible supports
- Examining current relationship dynamics
- Explaining the change process

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Identifying possible supports

- Must be patient driven
- May not always be “family”
  - *Cannot involve current or former abusers*
- Screening support ahead of time to lay groundwork for future work
- Those who cannot support may still be important sources of information
- You can attempt to plant seeds on unsupportive land

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Examining current relationship dynamics

- What does each person (patient and support person) have to gain or lose if the patient improves
- Is the support person safe?
- Does the support person have a repertoire of being able to be supportive?
- Is person “burned out” from previous interactions?
- Psychoeducation for the support person

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Explaining the change process

- Recognition of schema-related behaviors to be shared with support
- Practice bringing behaviors to light and reinforce change
  - Shaping toward functional; might require shaping toward less dysfunctional
- Realistic goals for change

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Adding other therapy options

- Group therapy to boost interpersonal awareness, interpersonal skill development, and modeling of others
- Couples therapy to assist with issues of intimacy (emotional and physical)
- Support groups

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Challenges and future directions

- Manualization of schema assessment and treatment
  - Including family involvement
- Few clinicians in the area do prolonged exposure / schema work
  - Will refer to any evidence-based therapist or previous referral
  - Train more clinicians in prolonged exposure
- More research is needed
  - Do schemas change?
  - Do schemas predict dropouts and/or treatment outcomes?

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Thank you for coming

Questions?

Chad.Wetterneck@rogersbh.org

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