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Magdalena Oleśniewicz

SCHEMA THERAPY IN THE TREATMENT OF DETENTION PATIENTS WITH ANTISOCIAL PERSONALITY STRUCTURE. EFFECTIVENESS AND MANAGEMENT METHODS

Humanitas University in Sosnowiec, Poland

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Summary

The author presents a modification of cognitive-behavioural therapy in the form of so-called schema therapy, developed in the 1990s, and its application in the treatment of antisocial personality disorder in criminal settings. The aim of schema therapy intended for detention patients with antisocial personality structure is to reduce early maladaptive schemas, which are responsible for psychological risk factors for crime and violence, as well as to build healthier coping strategies and extend protective factors. The effectiveness of schema therapy has been partially confirmed empirically. The article briefly describes the characteristics of patients with antisocial personality disorder. Possible therapeutic and corrective interventions that can reduce social criminal harm in this group of patients are presented. The basic assumptions of schema therapy, namely limited reparenting and empathic confrontation, are highlighted. The schema modes used in therapy, the process of building the therapeutic relationship and trust, and the skilful setting of boundaries are described. Differences and some modifications of schema therapy in this group are pointed out, and specific techniques and working tools are provided, with an outline of some relevant issues, recommendations, and limitations.

Introduction

Patients with personality disorders are often referred to as difficult and, regardless of the therapist's work paradigm or experience, are challenging. This is due to several reasons: (1) people with personality disorders are characterized by cognitive rigidity [1]; (2) they often come to therapy with unclear and chronic problems [2]; (3) patients' difficulties are ego syntonic, i.e. perceived by them as an integral part of their identity; patients treat their dysfunctional beliefs as an unquestionable truth about themselves; (4) the behavioural patterns hinder and complicate relationships with others; this area of work is often particularly problematic and has a significant impact on building the therapeutic relationship [2]. These factors considerably affect the therapy and, as a consequence, make the process of change much more difficult.

Patients with characteristics of antisocial personality disorder can be particularly challenging for clinicians owing to their propensity for manipulation, poor motivation to change, and impulsivity [2].

Schema therapy was developed in the 1990s by Jeffrey Young and his colleagues. It was conceived in response to difficulties in treating patients by means of a classical form of cognitive-behavioural therapy [2].

There is evidence for the effectiveness of schema therapy in the treatment of borderline personality disorder [3]. In the Polish language literature, there are relatively few publications on schema therapy in the context of antisocial personality disorder. The most recent reports suggest the effectiveness of this form of treatment among prison patients who meet the criteria for psychopathy and who, until now, have been considered untreatable [4].

In this article, I will present the concept of schema therapy in work with patients with antisocial personality, as it seems to be a promising option for this group. In the paper, I focus, among others, on European research that was conducted in forensic hospitals in the Netherlands and has been precisely described.

Schema therapy: general assumptions

In the treatment of personality disorders, schema therapy differs from the classic approach of the second-wave cognitive-behavioural therapy, although there are some common elements. Schema therapy combines standard cognitive-behavioural interventions with other approaches that are not traditionally applied in cognitive-behavioural therapy but are often essential when working with patients with personality disorders [2].

In the context of managing patients with antisocial personality disorder, schema therapy assumes that the psychotherapist will focus on three key elements: (1) therapeutic relationship (therapeutic alliance) — to teach patients to build safe bonds; (2) processing trauma, early childhood experiences of violence; (3) experiential techniques that focus on emotions and aim to help patients learn emotional self-regulation [5]. Schema therapy is intended as a medium- to long-term form of psychotherapy; it may last for 2–3 years or even longer in patients with personality disorders, e.g. antisocial, narcissistic, or borderline personality disorder [5].

Schema therapy theorists distinguish two basic mechanisms of schema function: reinforcement and healing. The individual, through their thoughts, feelings, and behaviour, can reinforce (intensify, expand) a schema or heal it (weaken it, eliminating its destructive effect). At the behavioural level, an individual unconsciously chooses situations and relationships that trigger and then reinforce their particular dysfunctional schema [6]. A schema is activated when a current situation resembles a childhood experience on the emotional and physiological level [7].

What is a relatively new concept in schema therapy is a schema mode. It was developed as a result of Young's observations of his own patients and their changing behaviour and

emotions during the sessions. A mode can denote changing emotional states: adaptive or maladaptive. The notion refers to a temporary emotional, cognitive, and behavioural state of an individual [8]. Working with modes is preferred when dealing with more difficult personality disorders, such as dissocial, narcissistic, borderline, or paranoid personality disorders, which are most prevalent in forensic settings [9].

Antisocial personality model and typical schemas

It is worth noting the variety of definitions or the terminological differences in the case of a disease entity such as persistent disorder of the personality structure, for which antisocial behaviour is a characteristic diagnostic criterion. According to the DSM-V diagnostic criteria for mental disorders, the entity described above is termed antisocial personality disorder. The ICD-10 International Classification of Diseases and Related Health Problems categorizes the same disorder as dissocial personality disorder. In this article, I use the expression 'antisocial personality disorder'. Its distinctive feature is socially irresponsible behaviour and lack of remorse. The problematic behaviours include failure to conform to social norms, impulsivity, difficulty in planning activities, irritability, and disregard for the rights of others [10]. People with antisocial personality disorder are also at risk of co-occurrence of other mental disorders, such as depression, bipolar affective disorder, anxiety disorders, attention deficit hyperactivity disorder, borderline personality disorder, and substance use disorders [10].

In individuals with a psychopathic personality structure (with antisocial personality disorder), the dominant schemas are as follows: (1) emotional deprivation, (2) social isolation, (3) abandonment / relationship instability, (4) defectiveness and shame, (5) emotional inhibition, (6) distrust/harm, (7) compliance, (8) vulnerability to injury or disease, (9) entitlement/grandiosity [11].

According to Beck, this group of patients is characterized by such basic beliefs as: 'I have to take care of myself,' 'Either I will be aggressive or I will become a victim,' 'Other people are wimps' [12]. Individuals with antisocial traits are self-centred, find it difficult to recognize other people's points of view, and have poor empathy skills [13]. Owing to early childhood experiences, they have learned to rely only on themselves, not to trust others. They are dominated by the fear of being used and humiliated. When interacting with others, patients with antisocial traits can be aggressive, argumentative and defensive [13]. There is a clear link between early maladaptive schemas and aggressive behaviour. The schemas of emotional deprivation and distrust/harm derive from the individual's unmet needs for love, security, care, and stability [14].

It can therefore be assumed that a patient with a psychopathic personality perceives themselves as unworthy of love and more lonely and rejected than individuals with a healthy personality structure. This leads to a coping style based on overcompensation ('Since I am weak, I must attack first, I cannot exhibit weakness,' 'I should hurt first, before someone

harms me') [14]. Patients with this personality structure perceive themselves as victims, and their main way of coping with this belief is to defend and attack [11]. Overcompensation behaviour is particularly difficult and discouraging in the clinical or therapeutic work with this group of patients.

Work techniques and therapeutic style

As in all cognitive-behavioural therapies, an accurate clinical diagnosis is a basic condition for commencing schema therapy. The therapist analyses the patient's reported problems and life history, collects information from a variety of sources, including questionnaires (e.g. the Young Schema Questionnaire, YSQ), reviews medical records, and observes the patient's behaviour and emotional states [5].

The basic principles of schema therapy involve limited reparenting and empathic confrontation [2, 6]. Reparenting implies that the therapist provides care and warmth, is available, and sometimes offers the patient guidance and support that they lacked in childhood. By applying empathic confrontation, the therapist confronts the patient with their maladaptive behaviour patterns, but does so in an empathic and non-threatening way [2, 6]. The non-evaluative language of schema therapy is particularly helpful here. In cases of more severe personality disorders, such as antisocial, narcissistic, or borderline personality disorder, which are frequently present in detention patients, some schema therapy modifications should be introduced [15].

Firstly, during the therapy, we operate mainly with schema modes. The therapist uses such concepts as 'part of you,' e.g. 'the part of you that avoids feelings,' 'the part of you that is excessively vigilant,' 'the part of you that puts yourself above other people'. In patients with antisocial personality disorder, it is particularly important to notice the Vulnerable child, Impulsive child, Angry child, and Bully and attack modes [16]. Cognitive techniques can be applied especially in the early stages of therapy. They help achieve intellectual distance from one's own schemas and emotional difficulties, but are usually insufficient because patients remain highly susceptible to emotional distress [17]. The schema therapist uses experiential techniques to enable the patient to emotionally process the maladaptive schemas — abandonment, emotional deprivation, distrust, shame — which, when triggered, can lead to criminal behaviour [17]. A typical example is chair work and a dialogue between the Vulnerable child and Demanding parent modes. Sitting in the Demanding parent's chair, the patient verbalizes any harsh demands and criticism. They then move to the child's chair and communicate how they feel when they hear these words. The therapist encourages the patient to express emotions rather than dry facts. The patient can change seats until all points of view have been articulated. The therapist affirms the importance of the child's needs and confronts the parental mode. It is crucial that the Demanding parent mode is overt and that it can be heard clearly, and thus then confronted and firmly addressed [5].

In the imagery technique, in turn, patients reprocess their painful experiences. The patient is asked to close their eyes and vividly imagine the current troublesome situation. The therapist then asks the patient to let the image of the current situation drift away and to connect the present emotions with a similar situation from childhood. The therapist follows what the patient is describing in the image and tries to change the aversive elements to meet some of the child's basic needs (e.g. the need for warmth, protection, attention). Such therapeutic interventions reduce the activation of schemas on a daily basis (schema healing) [17].

Considerable time and attention should also be dedicated to building an emotional relationship and therapeutic alliance with the patient, especially with a detention patient [17]. Detention patients with antisocial personality disorder often react suspiciously to attempts of establishing bonds. They maintain vigilance, using various modes to keep the therapist distant: they apply the Detached protector mode, cutting themselves off from emotions, or the Bully and attack mode, devaluing the therapist [5]. Nevertheless, in the therapeutic process, the therapist continues to focus on the patient's unmet emotional needs and uses such situations to confront the modes that block the therapeutic progress. The aim of all these interventions is to 'switch' the patient from the maladaptive mode into the Healthy adult mode; in this mode, the patient can reflect on themselves and take an action that is supportive and adaptive [5].

In the first phase of therapy, the focus is on building a therapeutic relationship and trust. In the middle phase (around the second year of therapy), experiential techniques are more frequently employed to allow emotional processing of schemas. The final phase (approximately the third year) concentrates primarily on maintaining the behavioural changes, as well as on reintegration with the community and other people.

Ultimately, therefore, the aim of schema therapy intended for detention patients with antisocial personality structure is to reduce early maladaptive schemas, which are responsible for psychological risk factors for crime and violence, as well as to build healthier coping strategies and extend protective factors [17].

Main schema therapy work techniques

Limited reparenting: meeting, through the therapeutic relationship, some of the patient's basic needs that were the major cause of frustration in childhood.
Empathic confrontation: confronting the patient, in an empathic way, with their maladaptive behavioural patterns that can be observed both during and beyond the therapy sessions.
Therapeutic relationship and a focus on the 'here and now': implementing therapeutic interventions 'here and now,' the therapist's responding to the patient's behaviour concerning the therapeutic relationship.
Cognitive techniques: challenging cognitive distortions through a Socratic dialogue.
Experiential techniques: emotional impact on early maladaptive schemas. Guided imagery, imagery rescripting, and chair work.
Behavioural techniques: modifying maladaptive behaviours by practising healthier alternative behaviours both during and beyond the therapy sessions.
Work with modes / chair work: combining any of the above techniques with an emphasis on working with a schema mode, on the 'here and now,' using a specific therapeutic 'language' when implementing interventions (e.g. 'Now I can see the part of you that...'). This is the main therapeutic technique designed to work with detention patients.

Source: own elaboration based on [2, 16]

Typical modes in the discussed group of patients and their application

In the schema therapy model and in the work with patients with personality disorders (especially those of cluster B), the main technique is based on modes (Table 1). Since patients with severe personality disorders often switch between emotional states very quickly, working with modes helps the therapist monitor and introduce appropriate therapeutic interventions during the therapy session. Research indicates that most patients with a trait or diagnosis of antisocial personality understand the concept of modes and quite quickly and intuitively learn to apply it in relation to themselves, unless their intelligence quotient is considerably below average (e.g. IQ > 80) [17].

According to schema therapy theory, the configuration of modes reflects well the complexity and specificity of the psychopathology of specific personality disorders [5].

A patient with antisocial personality disorder may oscillate between the emotionless detached mode of an Angry protector; compulsive efforts to self-soothe through the use of psychoactive substances or other addictive behaviour in the Detached self-soother/ self-stimulator mode; a sense of being superior and special in the Self-aggrandizer mode; extreme rage in response to narcissistic trauma, injustice, or abandonment in the Angry child mode; attempts at deception and manipulation in the Conning and manipulative mode; attempts to threaten others in the Bully and attack mode; and ruthless acts of violence intended to eliminate a threat, rival, or encountered obstacle in the Predator mode [16]. Criminal behaviour is thus understood in terms of modes and switching between modes [5].

In accordance with this model, a trigger of criminal behaviour consists in activating one of the childish modes, e.g. when a person with an antisocial personality feels abandoned, humiliated, lonely, or angry. There is a rapid switch to one of the overcompensation modes, and criminal behaviour occurs. For example, the partner refuses sexual acts, making the patient feel inferior (the Humiliated child mode), frustrated (the Impulsive child mode), and angry (the Angry child mode). To cope with these feelings, the patient applies one of the modes based on overcompensation [16]. The schema therapy model helps better understand and treat criminal and aggressive behaviour. Predominant maladaptive schema modes are considered as psychological risk factors for criminal or antisocial behaviour [16].

The goal of working with modes is to alleviate or eliminate the patient's maladaptive behaviour and to develop a stronger Healthy adult mode, which can help them meet their basic emotional needs in a more adaptive and effective way.

Table 1. **Characteristics of modes in the antisocial personality model**

Maladaptive childish modes	
1. Vulnerable child; abandoned, abused, humiliated child	The patient feels vulnerable, overwhelmed by pain and such feelings as sadness, humiliation, shame, loneliness
2. Angry child	The patient feels and expresses uncontrolled anger or rage in response to perceived or real abandonment, humiliation, frustration. They often feel unfairly treated. They behave like a child during a tantrum
3. Impulsive, undisciplined child	The patient releases all impulsive emotions. They seek immediate satisfaction of their needs, regardless of the 'here and now' circumstances. They are unable to postpone gratification and cannot tolerate frustrations arising from limitations
4. Lonely child	The patient feels loneliness, emotional emptiness, as if nobody can understand them, calm them down, comfort them, enter into contact with them
Maladaptive coping modes	
5. Detached protector	The patient distances themselves from others, thus protecting themselves from experiencing painful feelings and emotions. They seem emotionally distant, act like a robot, avoid approaching people
6. Detached self-soother/self-stimulator	The patient engages in various activities to distract from unpleasant emotions. These can be both soothing and calming activities (sleep) and stimulating activities (sex, substance use, sport). A sense of excitement is supposed to help the patient detach from painful feelings
7. Compliant surrenderer	The patient submits to the real or perceived demands of others to avoid potential negative consequences. They hope that when they are obedient, they will gain acceptance
8. Angry protector	The patient tries to distance others from themselves through anger. This mode arises especially against those who appear hostile and threatening. In this mode, the patient controls their anger better than in the Angry child mode

table continued on the next page

Maladaptive parental modes	
9. Punitive, critical parent	The patient is critical, unforgiving, aggressive, and punitive towards themselves. This is how the internalized voice of a parent (or some other significant person) manifests itself. The patient is dominated by feelings of guilt and shame
10. Demanding parent	The patient imposes high standards and demands on themselves, they are almost never satisfied with themselves
Maladaptive coping modes based on overcompensation (extreme forms of coping with feelings of shame, vulnerability, loneliness)	
11. Self-aggrandizer	The patient feels superior, special, strong. They look down on others, show off, are conceited and arrogant, not interested in other people's feelings or in contact with them. They exalt themselves and devalue others
12. Bully and attack mode	The patient uses threats, intimidation, aggression, or force to protect themselves from harm. In this way, they also try to obtain what they need at a given moment. They want to dominate and take sadistic pleasure in hurting others. This mode prevails in strong, extreme emotions
13. Conning and manipulative mode	The patient manipulates, behaves dishonestly to obtain what they want. This mode occurs in people with a criminal history when they want to avoid punishment or achieve a specific goal
14. Predator	The patient focuses on eliminating a threat, rival, or obstacle. They behave in a calculated, unscrupulous, and ruthless manner
15. Over-controller	To protect themselves from harm or (perceived) threat, the patient is extremely controlling. They may employ a variety of rituals for this

Source: own elaboration based on [2, 16]

A case study

Schema therapy theory may be well illustrated by the following case study, describing a quite effective treatment of an antisocial patient, presented by David P. Bernstein and colleagues. After therapy, the patient showed more insight and empathy and exhibited better communication skills than before treatment. These observations are consistent with the results of recent studies demonstrating that some psychopathic patients may benefit from treatment [4].

Andy (name changed), a 25-year-old white Dutch male, was sentenced to 3 years in prison for a sexual offence that he had committed. Andy is an only child and was raised by young parents. He recalls that his father was authoritarian and regularly used physical violence against him, usually when Andy did not do something in the way his father expected him to. The mother, on the other hand, was a quiet, submissive woman, who also regularly experienced violence from her husband. At the age of 8, Andy began to

exhibit more and more oppositional and rebellious behaviour. He repeatedly committed thefts (in shops, among relatives). At the age of 16, he began experimenting with psychoactive substances (attempts to detach himself from his emotions) and did not graduate from secondary school. In addition to thefts, Andy also committed assaults. He was first convicted of assault at the age of 17. When he was 18, his parents divorced. Andy did not develop a stable, secure relationship with either parent. His father was often harsh and punitive, his mother was distant and emotionally absent. At the age of 19, Andy was sentenced for a sexual offence for the first time. At that time, he explained that the assaulted woman 'was to blame herself'. Andy started his schema therapy in a facility for detention patients 6 months after his conviction, and the therapy lasted for 4 years [4]. The therapist established a therapeutic contract with the patient and set clear behavioural therapeutic goals; he also focused on psycho-educating the patient about his schema modes. In the course of therapy, Andy learned to recognize triggers (mainly the perceived authoritative behaviours) and to deal with them through stop signs, as well as avoidance of or withdrawal from such situations. Limited reparenting, boundary setting, and empathic confrontation were of key significance in Andy's psychotherapy. His primary needs were security, stability, trustworthiness (e.g. keeping contracts), honesty, including admitting mistakes, and emotional support from the therapist. These basic emotional needs often remain unmet in patients with psychopathic personality [4]. In the early therapy phase, Andy would check if the therapist followed the arrangements, and would be distrustful when the therapist was late. The therapist was able to admit his mistakes and encouraged the patient to explore his emotions by applying the chair work technique. The therapist also often used empathic confrontation with respect to coping modes, e.g. 'I know that this is a defensive part of you, but I feel threatened when you talk to me like this'. Despite difficult situations, the therapist tried to be open and honest. He used experiential techniques to go back to the patient's early experiences at an emotional level when his needs were not sufficiently met. Initially, Andy was afraid of losing control during these exercises and considered them 'artificial'. However, the therapist repeated the invitation from time to time and encouraged the patient by suggesting that they could stop the exercise at any time. The therapist started each exercise with an image of a 'safe place': Andy was asked to close his eyes and imagine himself in a quiet, safe place. The key interventions in the course of Andy's therapy were chair work, imagery rescripting, and empathic confrontation [4]. The imagery exercises included vivid memories of the physical and emotional abuse that Andy suffered from his father. In an exercise of imagery rescripting, Andy recalled a day when he was 8 years old and his father locked him in the car on a hot day without food or water. The therapist asked the patient for permission to appear in the imagination so that he could protect the child and meet his emotional needs. During the imagery exercise, the therapist firmly confronted the father, taking the child's side. By practising these exercises, Andy increasingly understood the compensatory nature of his aggression and recognized that this was how he tried to avoid being a victim in his later adult life.

Over the course of the therapy, Andy began to trust his therapist more and more, and a relationship developed between them. Andy could see that the psychotherapist was a 'flesh and blood person' and not just a cold professional. The trust was very important to Andy. Although the therapist realized that Andy was not always telling the truth, he tried to understand and listen to the patient.

In his work with Andy, the psychotherapist tried to support the healthy part of him that wanted to be honest, open, and sometimes genuinely vulnerable. In the first phase of the therapy, impulsive coping modes were more pronounced; in the later phase, the therapist had more access to the sensitive part of the patient. In the course of the therapy, Andy made considerable progress. Antisocial modes, such as the Predator mode, became less intense than at the beginning. Andy's primary schema was that of distrust/harm (expecting to be deceived or hurt by others). When distrust appeared, Andy reacted with aggression. The change achieved during the therapy was that Andy could identify the cause of his behaviour more quickly and seek a constructive solution.

The aim of therapy in patients similar to Andy (with antisocial personality) is to break the chain of violence that emerges as a result of the switching maladaptive schema modes [4].

Specific issues and recommendations

Schema therapists working among detention individuals may be frightened by visions of violence and manipulation on the part of patients. In addition, patients are usually mandatorily referred to treatment, which can significantly conflict with their motivation for therapeutic work. Although detention patients are often described as unmotivated [18], research indicates that motivation is a dynamic process [19]. In schema therapy, variable motivation is viewed in terms of switching modes, e.g. the Detached protector mode, blocking the access to emotions and feelings; the Bully and attack mode, involving an attempt to dominate and devalue the therapist; or the Over-controller mode, manifested by sensitivity to any signs of the therapist's unreliability. In schema therapy, the therapist avoids fighting with the patient; they take on the role of a friendly observer who examines the advantages and disadvantages of the patient's modes, helping the patient decide for themselves and ultimately choose whether and where they want to change their behaviour [5].

Dysfunctional schemas and schema modes will 'fight' to stay present at all costs because change seems dangerous and threatening, and old schemas are familiar and safe, though maladaptive [5]. In schema therapy, it is not necessary for the patient to be 'motivated' for treatment. The approach is intended for people with complex psychological problems and personality disorders. Patient motivation is therefore perceived in terms of schema modes, which are activated at specific moments. Thus, the level of motivation can change along with emotional states [17].

A patient in the Detached protector mode may say under strong emotion: 'Don't ask me about my feelings. I don't feel anything'. The aim of the therapeutic work is to reach

the sensitive part of the patient, where they are in direct contact with their feelings, and to reinforce the Healthy adult attitude, allowing the patient to reflect on the situation in a balanced and objective way [17].

Another key issue in working with this group of patients is to notice the specific schema modes that can be termed 'forensic' and that do not occur, or at least are not common, in the general psychiatric population. These are precisely the modes that constitute psychological risk factors for crime and violence, as well as increase the probability of aggressive, impulsive, and antisocial behaviour [5].

A further crucial point is the skilful setting of boundaries. It is very important that the schema therapist appoints boundaries in a clear and assertive way, but not being punitive (reflecting the Punitive parent mode) [2]. Forensic patients present a specific challenge to therapists. However, the schema therapy model provides the therapist with effective tools to manage these challenges. One should bear in mind that schema therapy is a complex and long-term process that requires specialist training, assessment of one's own therapeutic competence, and regular supervision. It is recommended that the therapists have at least three years of experience in therapeutic work [16]. A high score on the psychopathy scale (PCL-R) is not a criterion for exclusion from treatment with this method. Conditions that may constitute contraindications to schema therapy include low intelligence quotient, neurological disorders, autism spectrum disorders, and certain psychotic disorders, but the patient's use of psychotropic medication is not a condition for exclusion [16].

Empirical studies

The effectiveness of schema therapy among individuals with personality disorders has been confirmed in several studies [20–23]. Chakhssi et al. [4] examined the association of maladaptive schemas with aspects of psychopathy. They indicated that antisocial personality structure was significantly related to such schemas as distrust/harm and insufficient self-control.

Keulen-de Vos and Bernstein [24] analysed the relationship between schema modes and the committed crimes by exploring the criminal records of 95 offenders with cluster B personality disorders, including psychopathy. The criminal behaviour was usually preceded by the emergence of childish modes in these individuals (Vulnerable child, Impulsive child), followed by overcompensation modes (Predator, Bully and attack mode) or the Detached self-soother/self-stimulator mode. In turn, Bernstein et al. [17] investigated a group of patients with narcissistic, psychopathic, and borderline personality disorders, all judicially referred for treatment after violent crimes. They were assessed at the study commencement and at 6-month intervals over 3 years by using measures that were not dependent on the patients' self-reports for most variables. The patients (mainly men) undergoing schema therapy achieved significantly better results than those treated conventionally in terms

of numerous variables, exhibited fewer symptoms of psychopathy, and integrated better with their cellmates.

Conclusions

The described schema therapy model applied in patients with antisocial personality structure judicially referred for treatment is increasingly regarded as promising. It allows for a coherent understanding and prevention of criminal behaviour. The basic principles of schema therapy involve limited reparenting and empathic confrontation [2, 6]. Non-evaluative language is particularly helpful in confronting patients with their problematic behaviour.

Standard cognitive-behavioural techniques are of limited effectiveness in detention patients [25]. In turn, schema therapy may for several reasons constitute a more effective form of help for detention patients and those with a diagnosis of antisocial personality. Firstly, the theoretical model is quite consistent and transparent for both parties (the therapist and the patient); consequently, both parties gain a better understanding of the role of triggers. Secondly, schema therapy uses emotional processing techniques, not so common in classical cognitive-behavioural therapy.

In schema therapy, the therapeutic style is active, at times directive, involved, and goes beyond the change at the cognitive level (thoughts). A compassionate and humanistic approach is crucial. Finally, working with modes provides a conceptual framework and a clear set of interventions to support coping with variable emotional states by patients with more severe personality disorders. Schema therapy can prove rewarding in the work with detention patients; however, it is essential that the therapist is aware of the emerging schema modes that are not as prevalent in the general psychiatric population (e.g. the Predator mode, the Bully and attack mode) [16].

The integrative schema therapy model and its flexibility have advantages, disadvantages, and some limitations. The numerous therapeutic tools at the disposal of schema therapists — those focused on emotions, as well as relational, cognitive, and behavioural ones, among others — may introduce a certain freedom in their application [26]. The modes model both allows for a theoretical understanding of psychopathology and provides some pragmatic solutions focused on interventions, but further research into the empirical basis of schema therapy is still advisable. The research is necessary to confirm the proposed modifications, especially the relevance of specific impacts and interventions that are considered to facilitate the process of change [26].

More randomized controlled clinical trials would be desirable to compare the effectiveness of schema therapy with that of other therapeutic approaches [27]. The research should involve certain important issues: (1) the study group should be described in detail; (2) psychometric tools enabling broader generalizations should be used [27]. It is therefore pertinent that further research leads to more detailed and nuanced treatment protocols,

allowing interventions in individual patients (with specific diagnoses, needs, and modes) [26]. It is worthwhile to develop research on schema therapy in the criminal population and to precisely identify the needs and challenges concerning this group of patients, as well as the therapeutic interventions in order to broaden knowledge on the effects of this form of therapy and to bring out and correct its weaker aspects.

References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 4th ed. Washington: American Psychiatric Association; 1994.
2. Young JE, Klosko JS, Weishaar ME. Schema therapy: a practitioner's guide. New York: Guilford Press; 2003.
3. Giesen-Bloo J, van Dyck R, Spinhoven P, van Tilburg W, Dirksen C, van Asselt T et al. Outpatient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs transference-focused psychotherapy. Arch. Gen. Psychiatry 2006; 63(6): 649–658.
4. Chakhssi F, Kersten T, de Ruiter C, Bernstein DP. Treating the untreatable: a single case study of a psychopathic inpatient treated with schema therapy. Psychotherapy 2014; 51(3): 447–461.
5. Keulen-de Vos M, Bernstein DP, Arntz A. Schema therapy for aggressive offenders with personality disorders. In: Tafrate RC, Mitchell D, eds. Forensic CBT: a handbook for clinical practice. Chichester: Wiley Blackwell; 2013, p. 66–84.
6. Young JE. Cognitive therapy for personality disorders: a schema-focused approach. Sarasota: Professional Resource Exchange; 1990.
7. Roediger E, Stevens BA, Brockman R. Kontekstualna terapia schematów. Gdańsk: GWP; 2021.
8. Yakin D, Grasman R, Arntz A. Schema modes as a common mechanism of change in personality pathology and functioning: results from a randomized controlled trial. Behav. Res. Ther. 2020; 126: 103553.
9. De Ruiter C, Hildebrand M. Risk assessment and treatment in Dutch forensic psychiatry. Neth. J. Psychol. 2007; 63(4): 152–160.
10. Black DW. The treatment of antisocial personality disorder. Curr. Treat. Options Psychiatry 2017; 4: 295–302.
11. Özdel K, Türkçapar MH, Guriz SO, Hamamci Z, Duy B, Taymur I et al. Early maladaptive schemas and core beliefs in antisocial personality disorder. Int. J. Cogn. Ther. 2015; 8(4): 306–317.
12. Beck AT, Freeman A, Davis DD, eds. Cognitive therapy of personality disorders, 2nd ed. New York: Guilford Press; 2004.
13. Beck AT, Davis DD, Freeman A, eds. Cognitive therapy of personality disorders, 3rd ed. New York: Guilford Publications; 2015.
14. Sargin AE, Özdel K, Türkçapar MH. Cognitive-behavioral theory and treatment of antisocial personality disorder. In: Durbano F, ed. Psychopathy — new updates on an old phenomenon. Rijeka: IntechOpen; 2017, p. 99–116.
15. Leue A, Borchard B, Hoyer J. Mental disorders in a forensic sample of sexual offenders. Eur. Psychiatry 2004; 19(3): 123–130.

16. Bernstein DP, Arntz A, Keulen-de Vos M. Schema focused therapy in forensic settings: theoretical model and recommendations for best clinical practice. Int. J. Forensic Ment. Health 2007; 6(2): 169–183.
17. Bernstein DP, Clercx M, Keulen-de Vos M. Schema therapy in forensic settings. In: Polaschek DLL, Day A, Hollin CR, eds. The Wiley international handbook of correctional psychology. Chichester: John Wiley & Sons; 2019, p. 654–668.
18. Howells K, Day A. Readiness for treatment in high-risk offenders with personality disorders. Psychol. Crime Law 2007; 13(1): 47–56.
19. Drieschner KH, Lammers SMM, van der Staak CPF. Treatment motivation: an attempt for clarification of an ambiguous concept. Clin. Psychol. Rev. 2004; 23(8): 1115–1137.
20. Jovev M, Jackson HJ. Early maladaptive schemas in personality disordered individuals. J. Pers. Disord. 2004; 18(5): 467–478.
21. Lobbestael J, Arntz A, Sieswerda S. Schema modes and childhood abuse in borderline and antisocial personality disorders. J. Behav. Ther. Exp. Psychiatry 2005; 36(3): 240–253.
22. Lobbestael J, Van Vreeswijk MF, Arntz A. An empirical test of schema mode conceptualizations in personality disorders. Behav. Res. Ther. 2008; 46(7): 854–860.
23. Nordahl HM, Holthe H, Haugum JA. Early maladaptive schemas in patients with or without personality disorders: does schema modification predict symptomatic relief? Clin. Psychol. Psychother. 2005; 12(2): 142–149.
24. Keulen-de Vos M, Bernstein DP. Schema therapy in forensic settings. In: Davies J, Nagi C, eds. Individual psychological therapies in forensic settings: research and practice. Abingdon: Routledge; 2016, p. 157–179.
25. Timmerman IGH, Emmelkamp PMG. The effects of cognitive-behavioral treatment for forensic inpatients. Int. J. Offender Ther. Comp. Criminol. 2005; 49(5): 590–606.
26. Rafaeli E, Maurer O, Thoma N. Working with modes in schema therapy. In: Thoma N, McKay D, eds. Engaging emotion in cognitive behavioral therapy: experiential techniques for promoting lasting change. New York: Guilford Publications; 2014, p. 263–287.
27. Schneider Bakos D, Gallo AE, Wainer R. Systematic review of the clinical effectiveness of schema therapy. Contemp. Behav. Health Care 2015; 1(1): 11–15.

Address: ma.olesniewicz@gmail.com