Schema Therapy for Cluster-C Personality Disorders

Arnoud Arntz

University of Amsterdam
Maastricht University

Disclosure

- Supported by grants
  - ZonMW, the Netherlands Organization for Health Research and Development
  - Netherlands Institute for Advanced Studies in the Humanities and Social Sciences (NIAS)
  - NWO/DFG (ORA international; with Gitta Jacob & Rainer Göbel)
  - Australian Rotary Health (PI Chris Lee)
  - Else Kröner-Fresenius-Stiftung (PI Gitta Jacob)
  - Netherlands Foundation for Mental Health
  - Netherlands Health Care Insurance Board. (Developmental Medicine)
- Author of books & chapters on ST
  - Wiley, Guilford, Nieuwezijds, Beltz
- Occasional trainer/workshop leader in ST

Ingredients of ST

- Integrative
  - Cognitive therapy, behavior therapy, experiential therapies (Gestalt), psychodynamic therapy, attachment theory & other developmental insights
  - Schema mode model (“ego states”)
  - Not eclectic ! Specific techniques for each mode
- 3 foci:
  - Therapeutic relationship (limited reparenting)
  - Childhood (traumas; early relationships)
  - Present (and future)

ST for 6 PDs (Cl-C; Nar, Par, Histr)

Bamelis et al. (2014) Am J Psychiatry

- Multicenter RCT: ST vs TAU vs COP
  - N = 320
- 50 session ST protocol
  - 40 sessions in yr 1; 10 booster sessions in yr 2
- COP = Clarification Oriented Psychotherapy
  - (specialized CCT, open-ended, Rainer Sachse)
- TAU = optimal psychological treatment at local site according to indication staff
  - indicated: 41.8% insight-oriented psychotherapy
    32.1% supportive psychotherapy
    20.9% CBT/EMDR

Results of a Multicenter Randomized Controlled Trial of the Clinical Effectiveness of Schema Therapy for Personality Disorders

Lotte L.M. Bamelis, Ph.D.

Silvia M.A.A. Evers, Ph.D.

Philip Spinhoven, Ph.D.

Arnoud Arntz, Ph.D.

Objective: The authors compared the effectiveness of 50 sessions of schema therapy with clarification-oriented psychotherapy and with treatment as usual among patients with cluster C, paranoid, histrionic, or narcissistic personality disorder.

Method: A multicenter randomized controlled trial, with a single-blind parallel design, was conducted between 2006 and 2011 in 12 Dutch mental health institutes. A total of 323 patients with personality disorders were randomly assigned (schema therapy, N=147; treatment as usual, N=135; clarification-oriented psychotherapy, N=41). There were two cohorts of schema therapy therapists, with the first trained primarily with lectures and the second primarily with exercises. The primary outcome was recovery from personality disorder 3 years after treatment started (assessed by blinded interviewers). Secondary outcomes were dropout rates and measures of personality disorder traits, depressive and anxiety disorders, general psychological complaints, general and social functioning, self-ideal discrepancy, and quality of life.

Results: A significantly greater proportion of patients recovered in schema therapy compared with treatment as usual and clarification-oriented psychotherapy. Second-cohort schema therapists had better results than first-cohort therapists. Clarification-oriented psychotherapy and treatment as usual did not differ. Findings did not vary with specific personality disorder diagnosis. Dropout was lower in the schema therapy and clarification-oriented psychotherapy conditions. All treatments showed improvements on secondary outcomes. Schema therapy patients had less depressive disorder and higher general and social functioning at follow-up. While interview-based measures demonstrated significant differences between treatments, differences were not found with self-report measures.

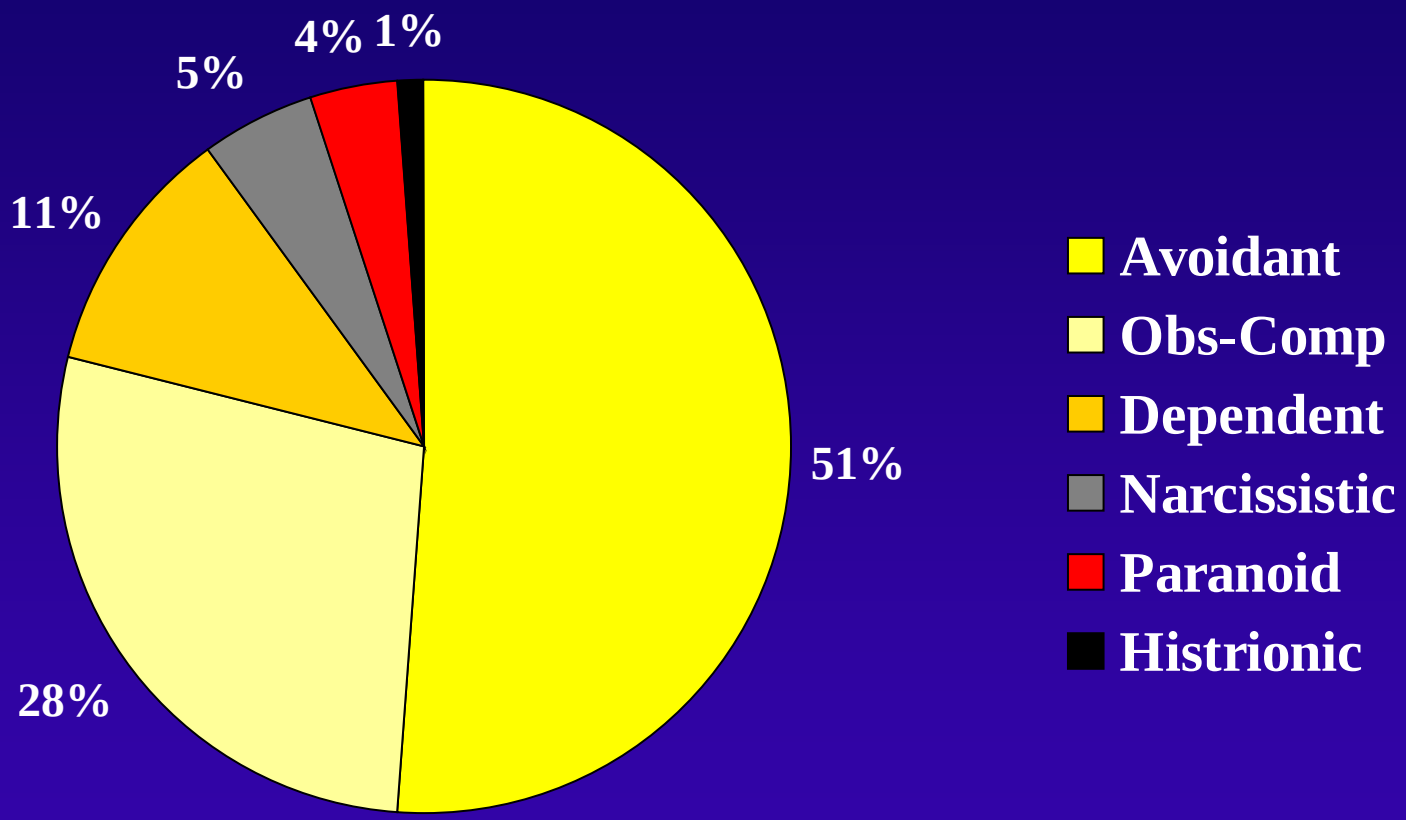
Conclusions: Schema therapy was superior to treatment as usual on recovery, other interview-based outcomes, and dropout. Exercise-based schema therapy training was superior to lecture-based training.

(Am J Psychiatry 2014; 171:305–322)

Sample

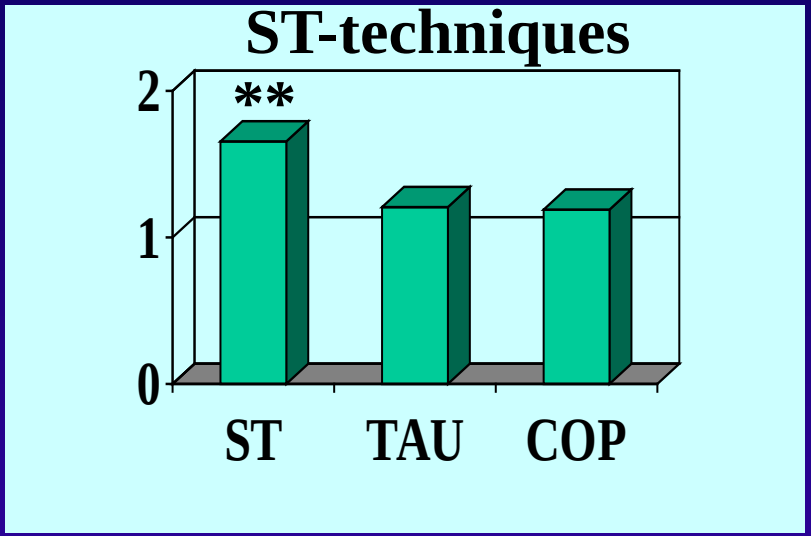
- 56.6% female
- Age = 39 (sd 9.5)
- # previous treatments = 2.4 (sd 2.3)
- 34.4% disability compensation
- 10.9% welfare
- 90 % Cluster-C as primary diagnosis
- ~ 70% life time depression on axis-1
- 44.7% current depression/dysthymia
- 58.4% anxiety disorder(s)
- 50.9% medication (at baseline)

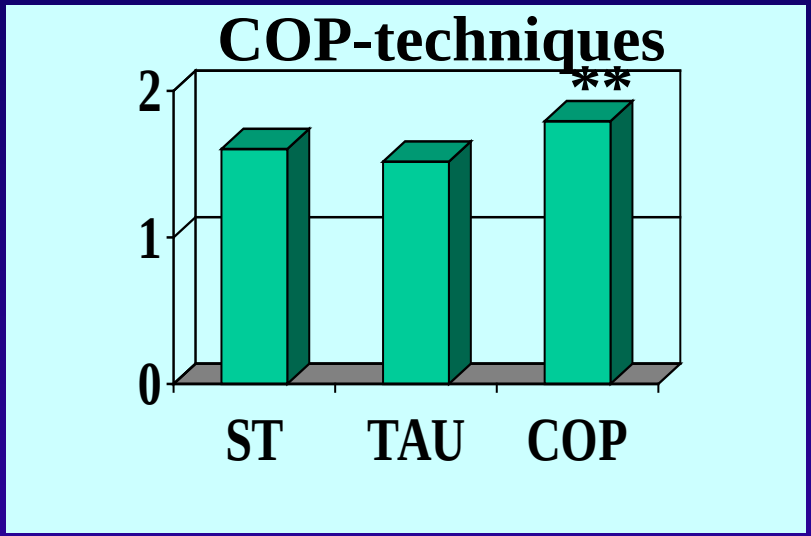
Primary Diagnosis (N=320)
90% Cl-C PD

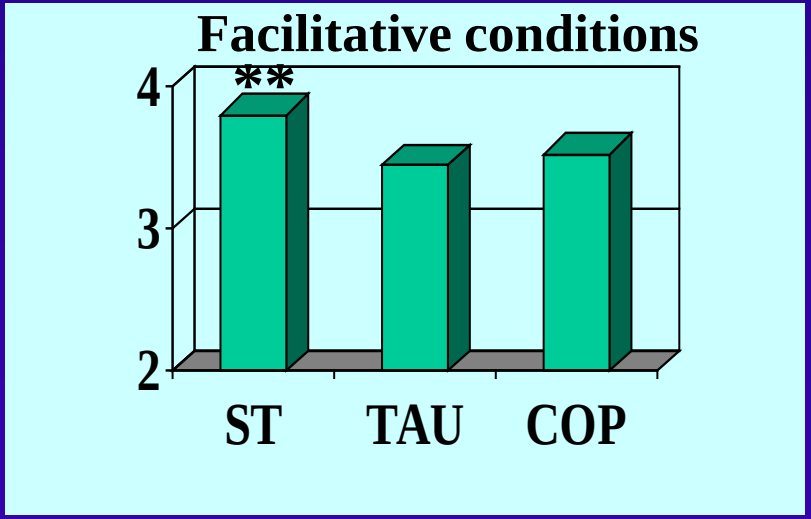


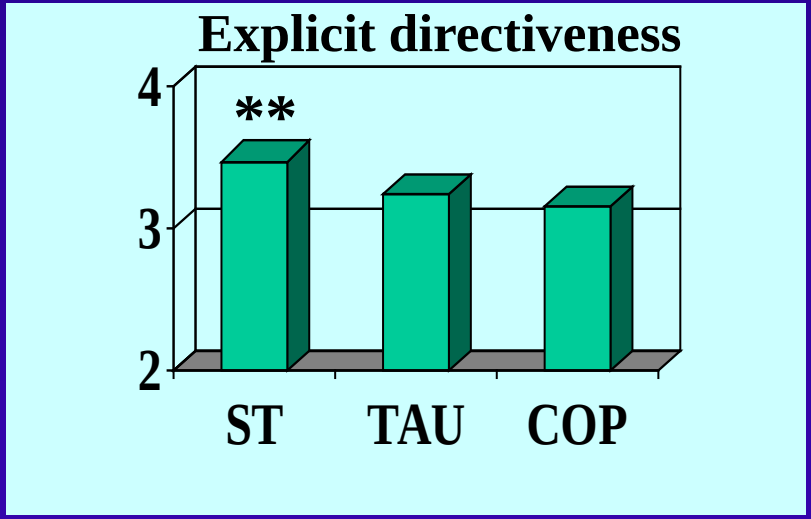
Treatment Integrity Check

(audiotapes raters blind for condition)





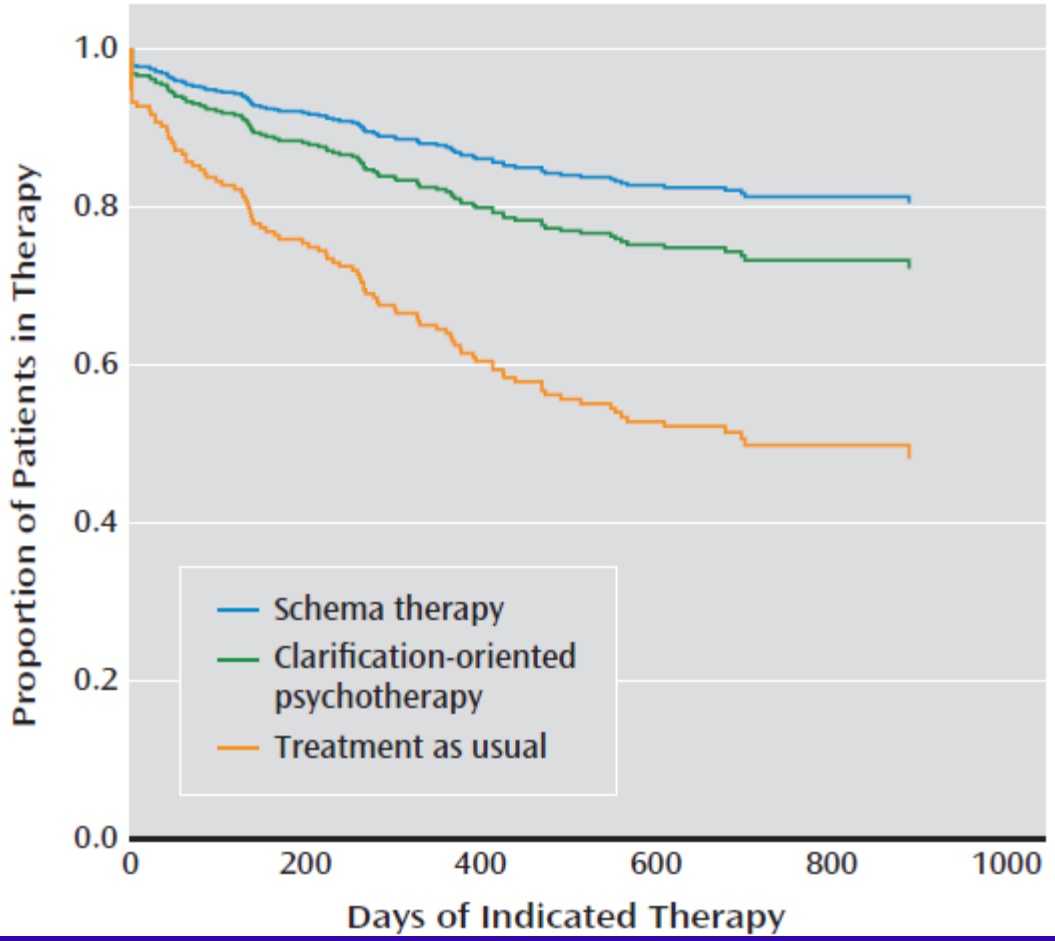




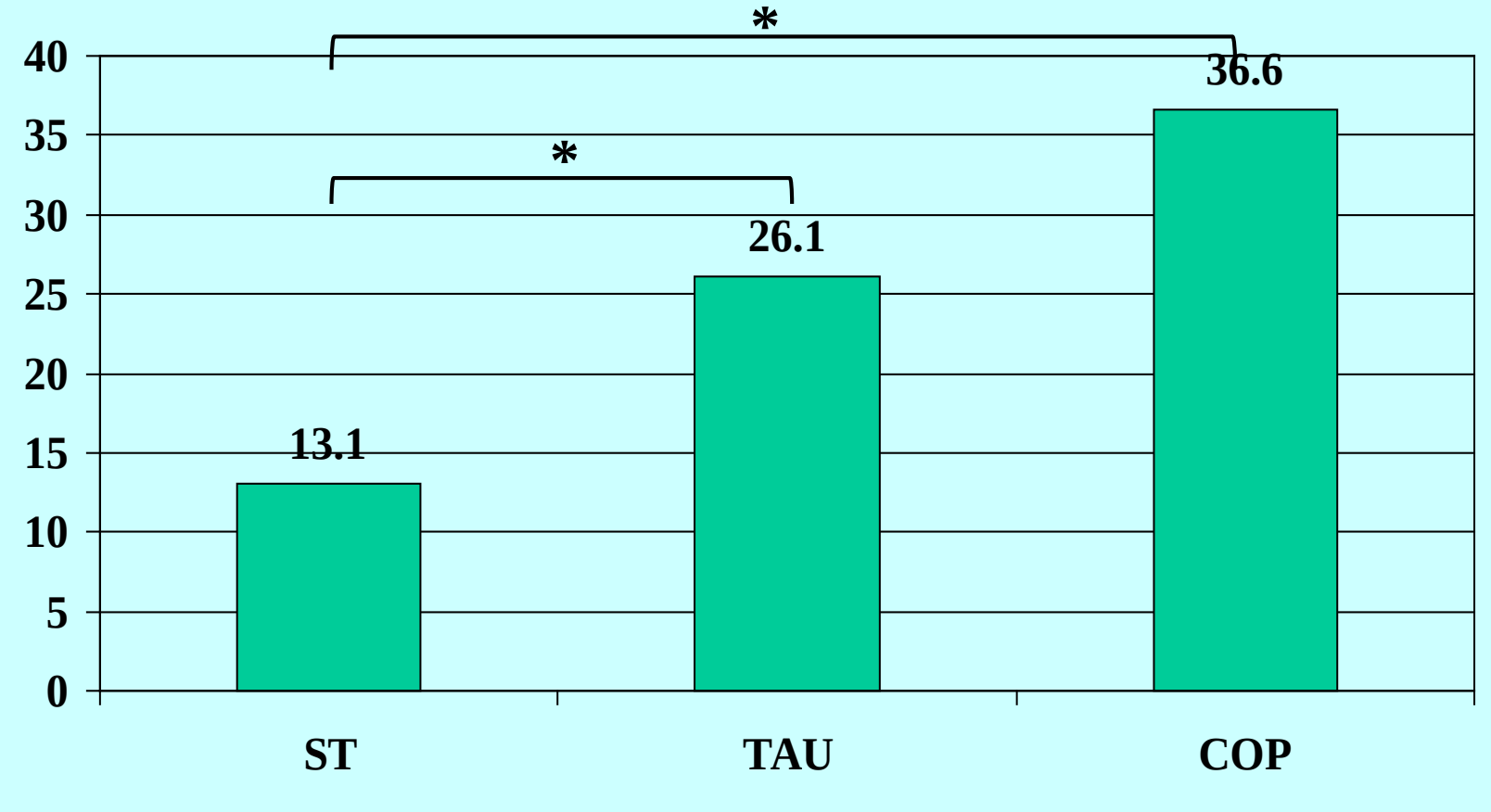
** p < .01

Treatment Retention

FIGURE 3. Proportion of Patients in Indicated Principal Treatment (Schema Therapy, Treatment as Usual, or Clarification-Oriented Psychotherapy)[a]



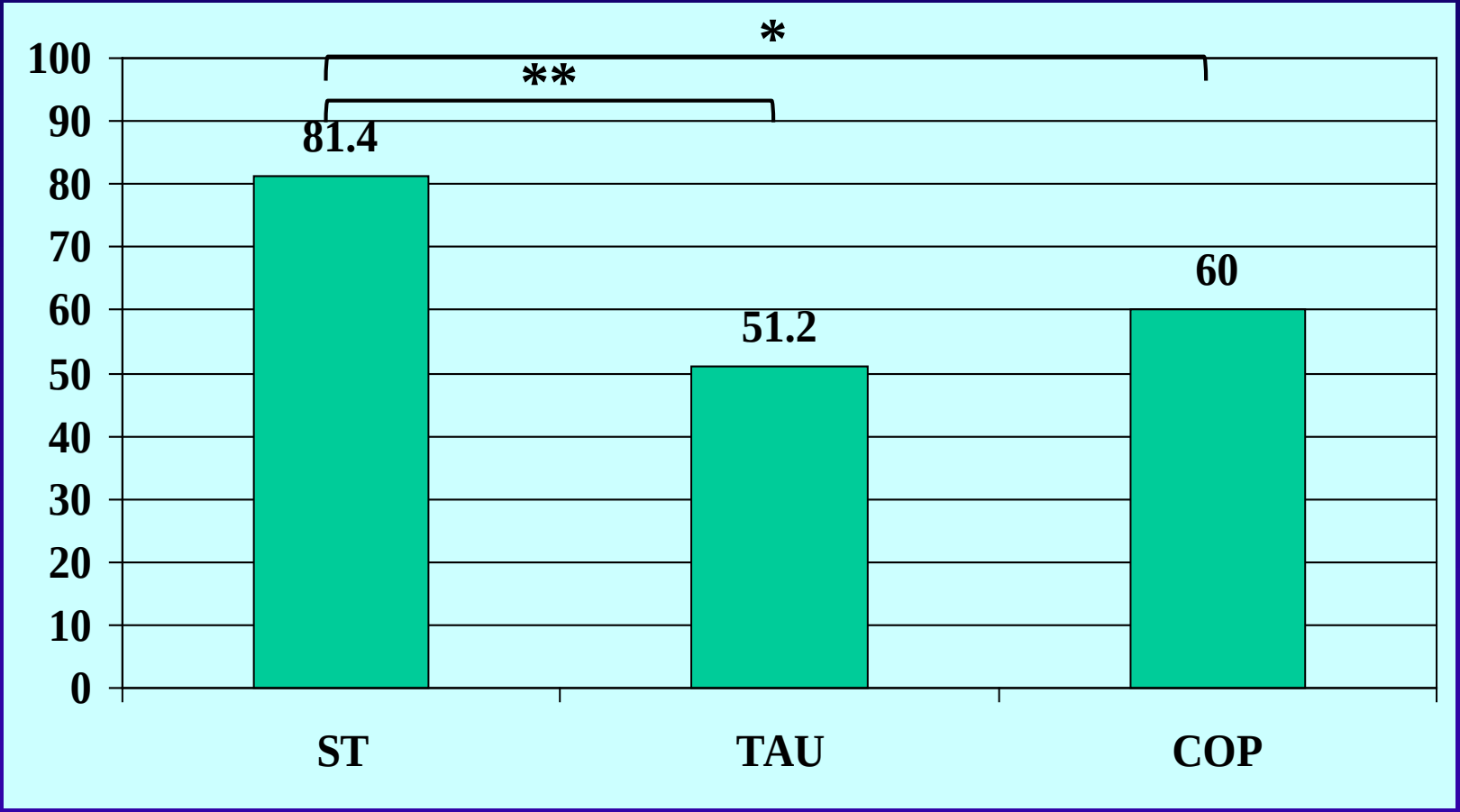
% still in treatment at 3 yr



*p < .05

% recovered from PD at 3 yr

primary outcome analysis

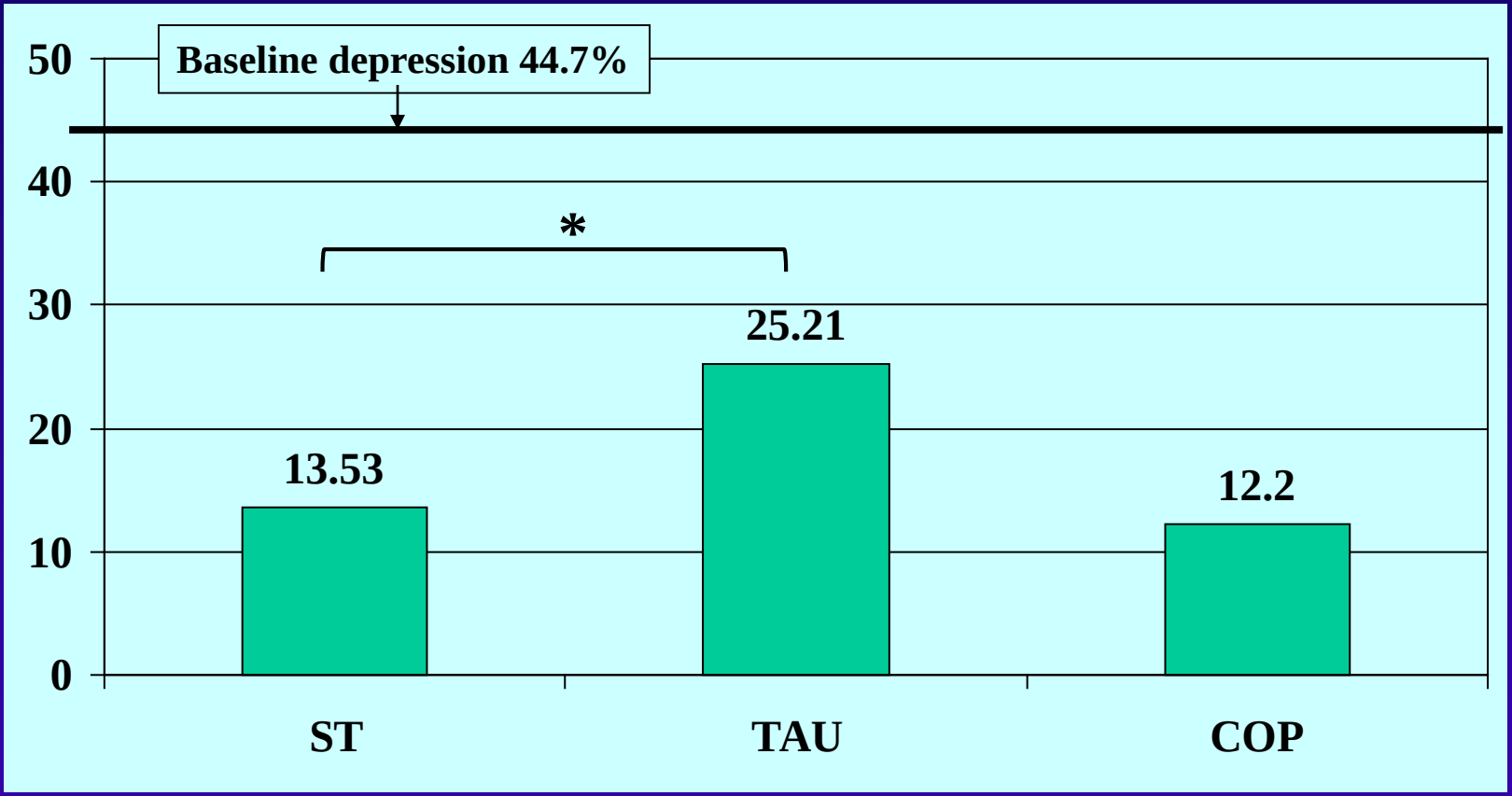


ST vs TAU: OR=4.1, p < .001

ST vs COP: OR=2.9, p < .05

% having depression at 3-yr follow-up

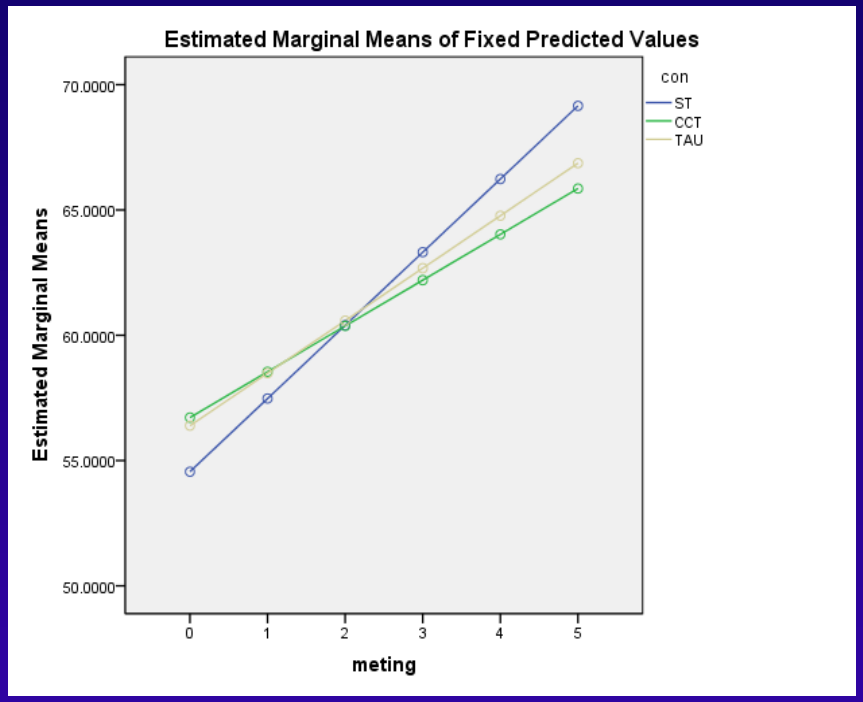
controlled for baseline depression



ST vs TAU: OR=0.23, p = .033

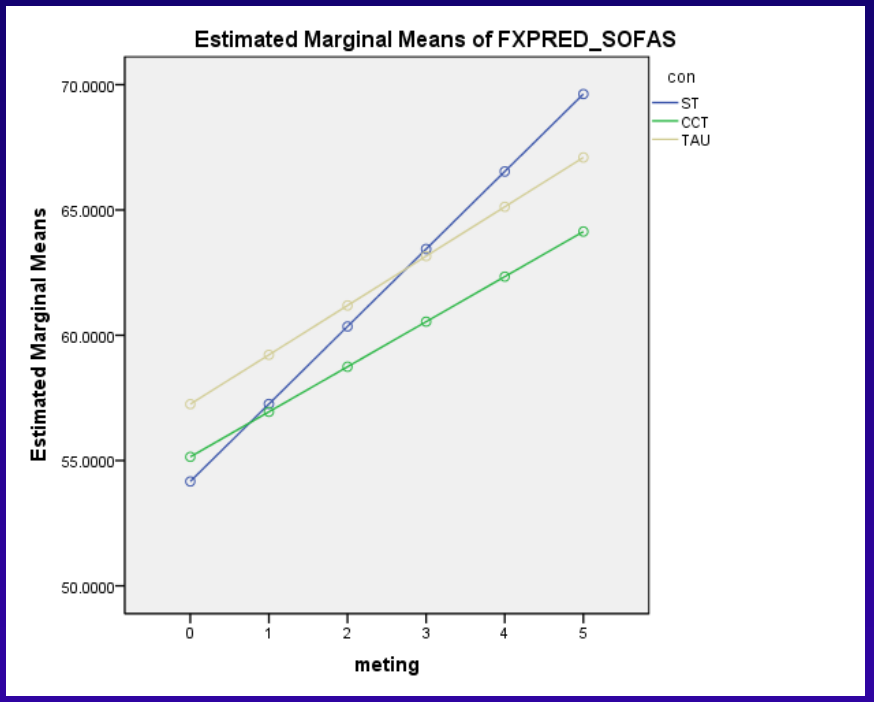
GAF & SOFAS scores over 3 yrs

GAF: ST > TAU



Cohen's d	
ST	1.76
COP	1.11
TAU	1.27

SOFAS: ST > TAU=CCT



Cohen's d	
ST	1.65
COP	0.93
TAU	1.05

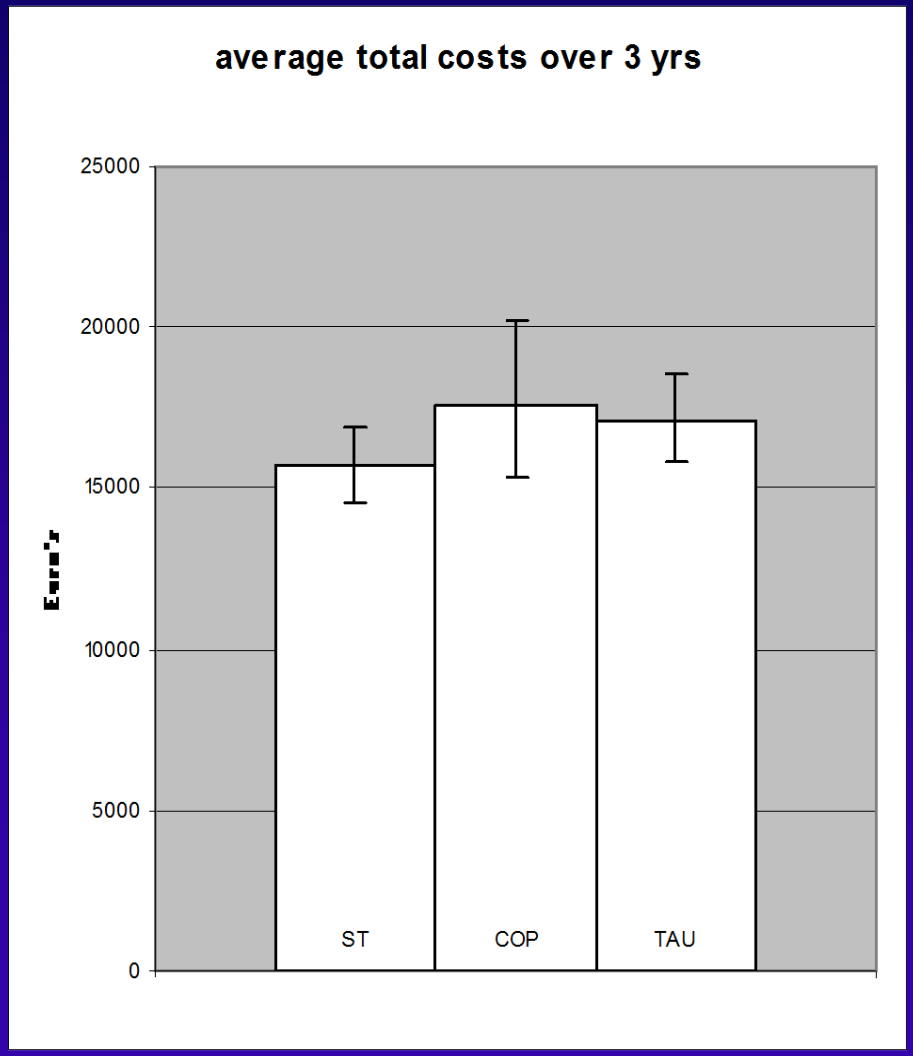
But

- No differences between treatments on self-report questionnaires
  - Good effects (large effect sizes)
- Extra effects of ST apparent on objectifiable indices (interviews), not on subjective reports
  - Change in self-view might lag behind objective changes (e.g., behavior)
  - Might also point to the important behavioral change part of ST

Cost-effectiveness

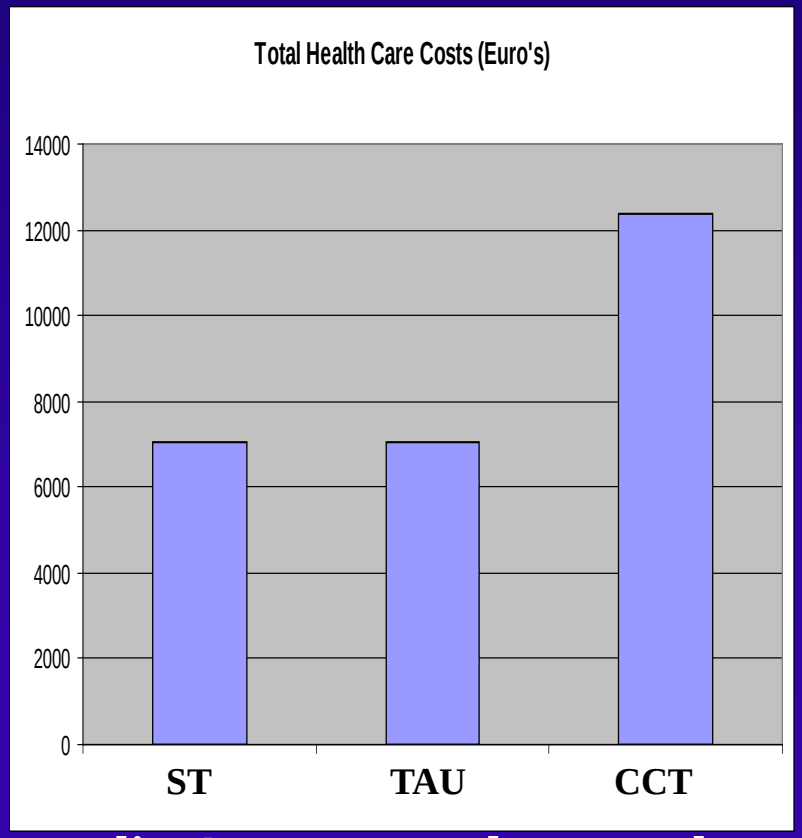
- Helps decision making: which health care should be implemented, which not?
- Two aspects:
  - Effects (e.g., new vs. usual treatment)
    - Usually *clinical* and *QALYs* (generic)
  - Societal costs (of new vs. usual treatment)
    - *Societal* to prevent that other sectors than health care get extra costs or are ignored (e.g., work; disability compensation, etc)

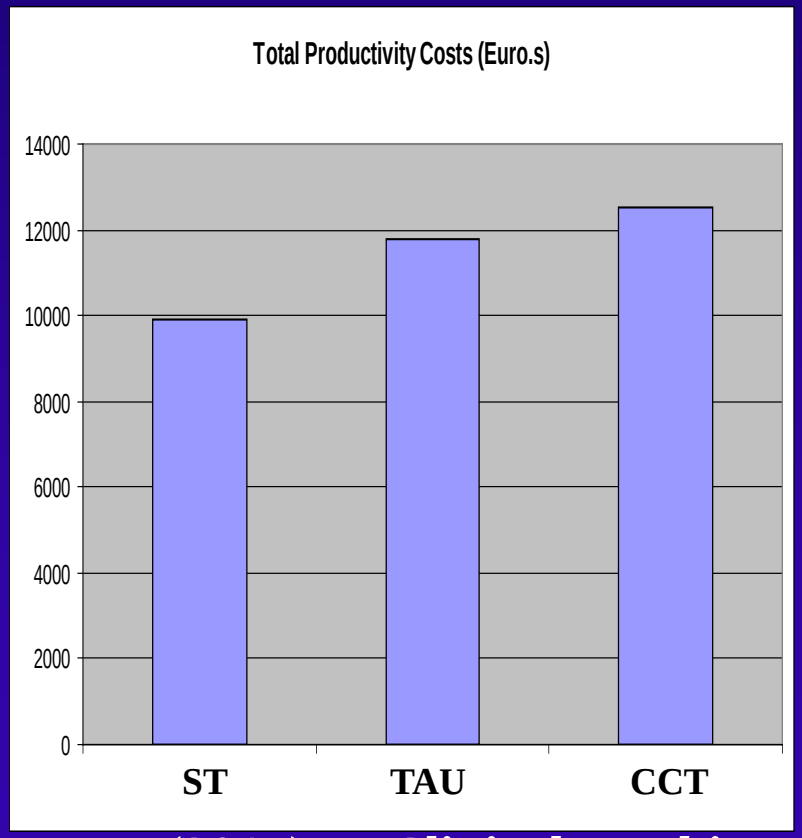
Societal Costs over 3 yrs



Bamelis, Arntz, Wetzelaer, Verdoorn & Evers (2015). *J. Clinical Psychiatry*

Cost-effectiveness Study: Health Care and Productivity Costs over 3 yrs





Bamelis, Arntz, Wetzelaer, Verdoorn & Evers (2015). *J. Clinical Psychiatry*

Cost-effectiveness

Bamelis, Arntz, Wetzelaer , Verdoorn & Evers. *J. Clinical Psychiatry, in press*

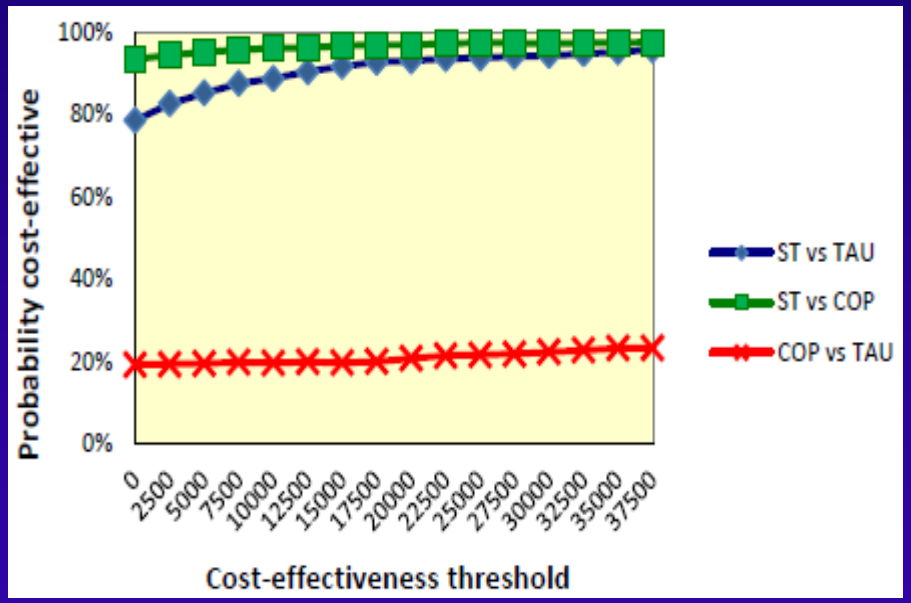
- ST is € 3000 cheaper per patient than TAU (on societal level)
- ST is more effective (81% vs. 51% recovery)
- Cost-effectiveness ratio:

$$\frac{\text{Costs ST} - \text{Costs TAU}}{\text{Effect ST} - \text{Effect TAU}} = \frac{-3000}{.3} = -10000$$

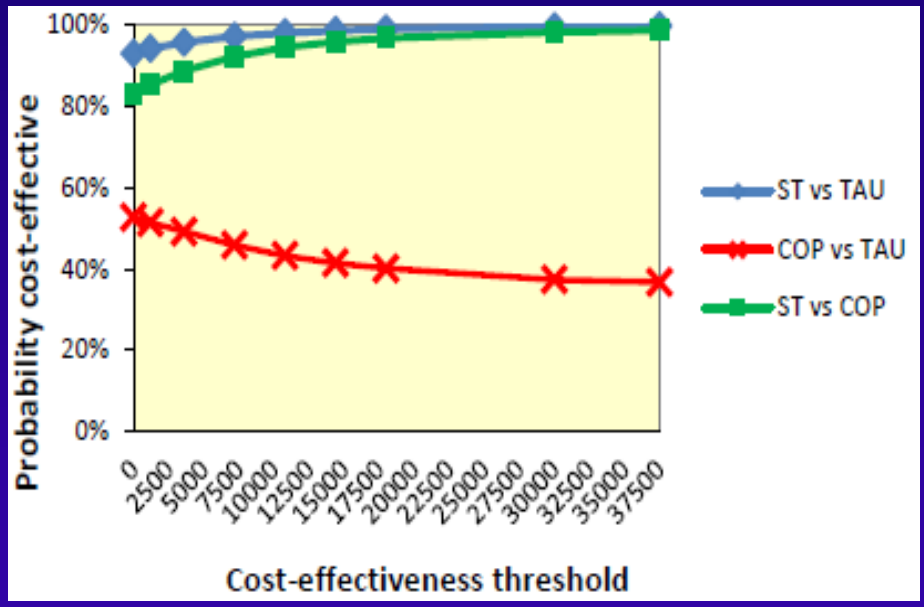
- Society gets back € 3000/.3 = € 10,000 for every extra recovered patient
- Important reason: ST patients return more/earlier to work

Probability that ST is more cost-effective as function of Lambda (willingness to pay) Clinical Outcome: Recovery

Bootstrap Analysis



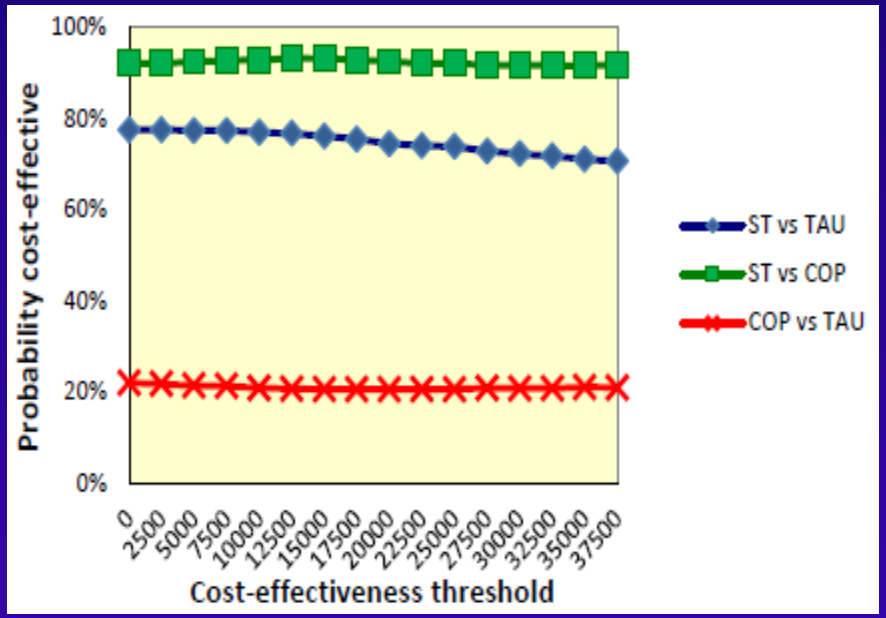
Multilevel Analysis



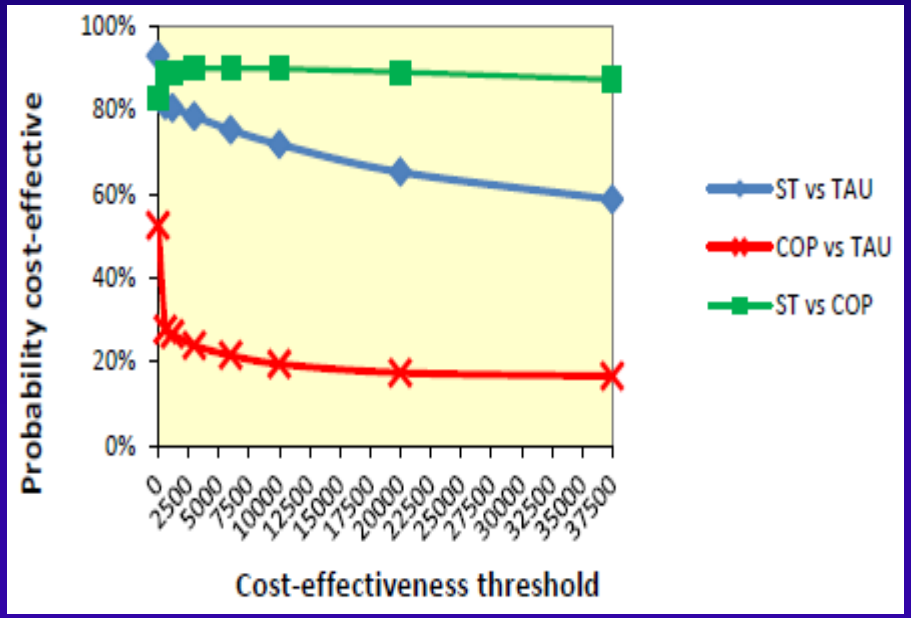
Bamelis, Arntz, Wetzelaer , Verdoorn & Evers (2015). *J. Clinical Psychiatry*

Probability that ST is more cost-effective as function of Lambda (willingness to pay) Outcome = QALYs

Bootstrap Analysis



Multilevel Analysis

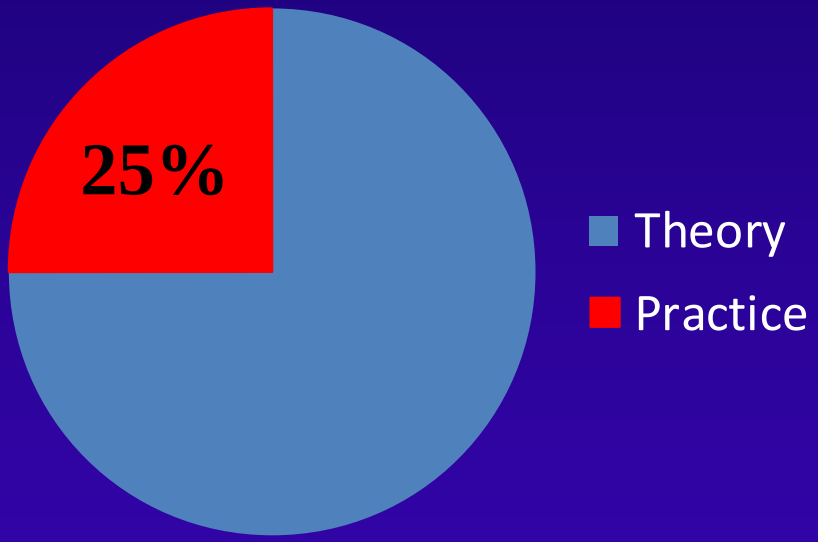


Bamelis, Arntz, Wetzelaer , Verdoorn & Evers (2015). *J. Clinical Psychiatry*

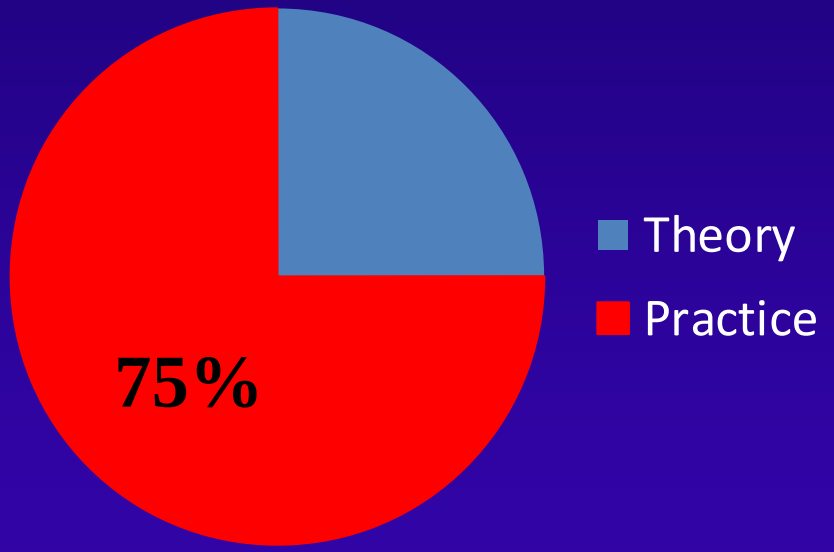
Therapist Cohorts

- Cohort 1 trained mainly by lectures and viewing video examples (4 days)
- Cohort 2 trained mainly by practicing (role plays) techniques after short explanation & life demonstration (4 days)

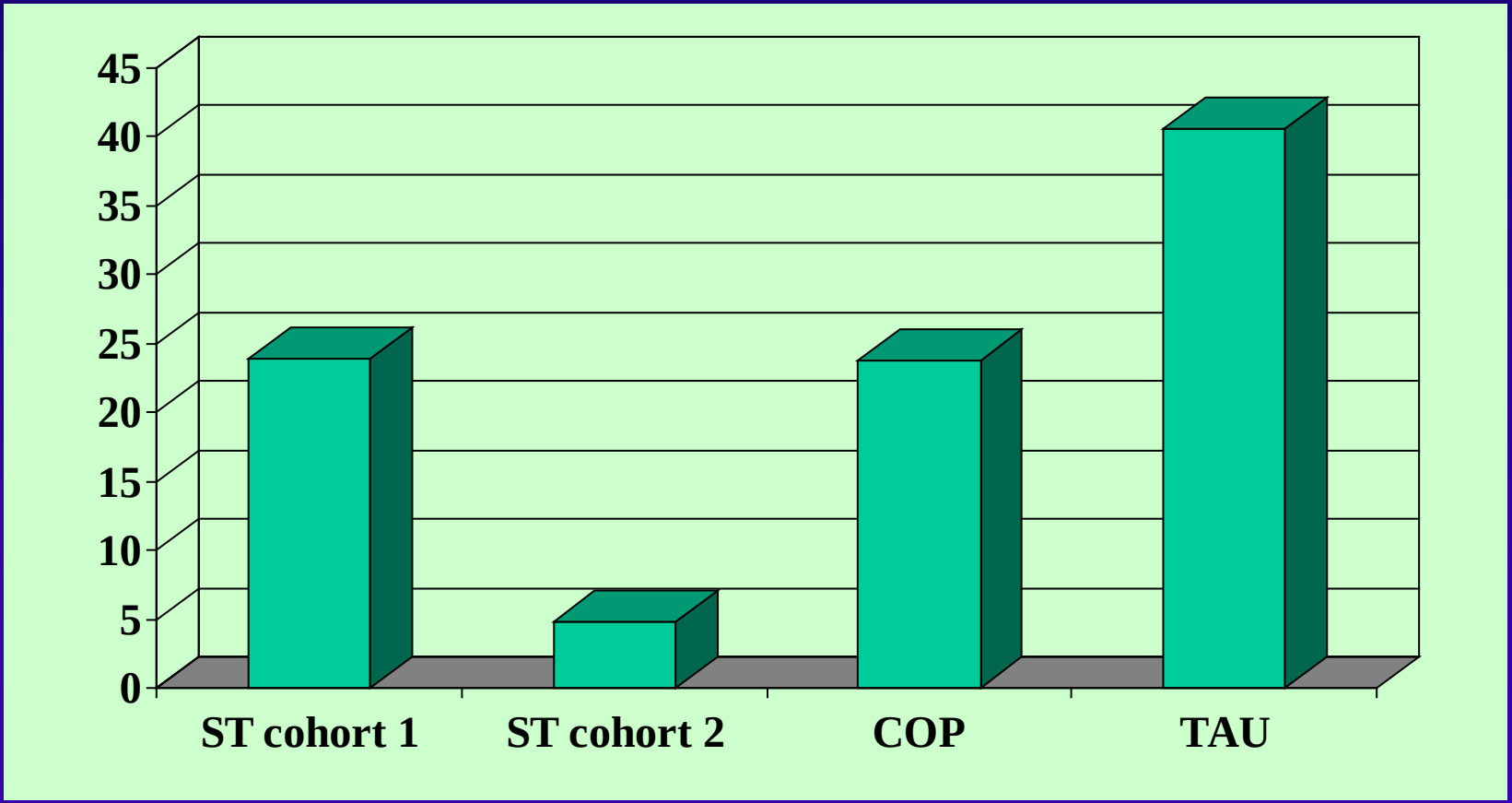
Cohort 1



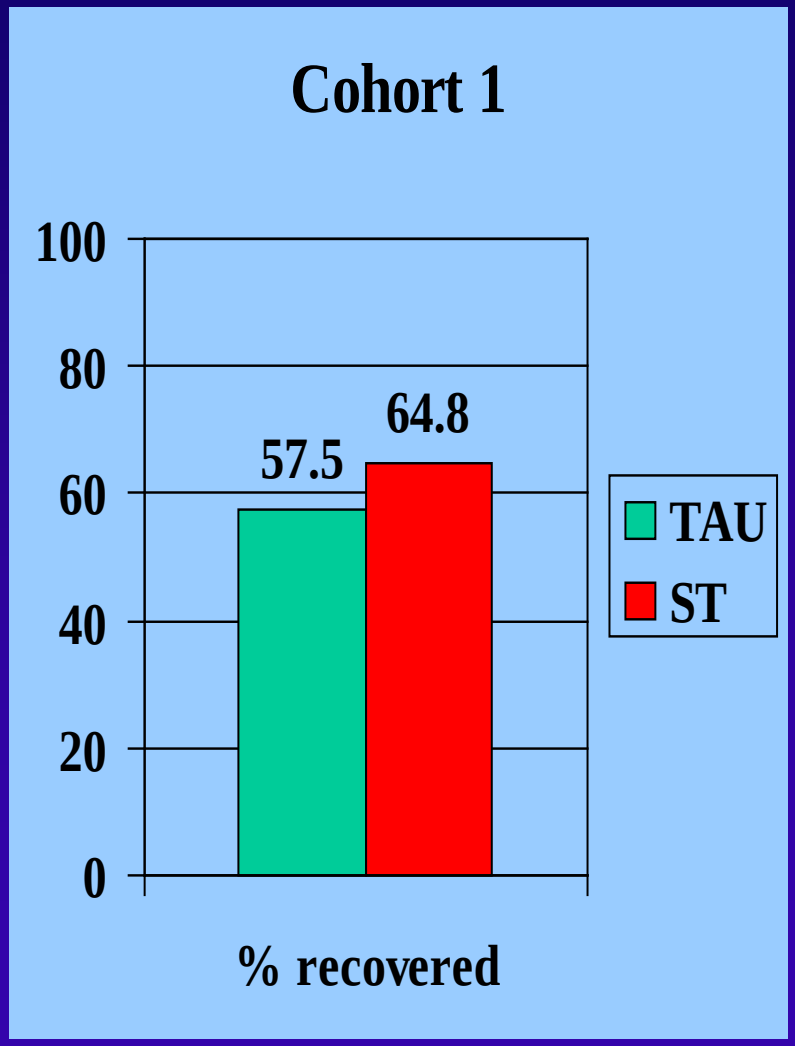
Cohort 2

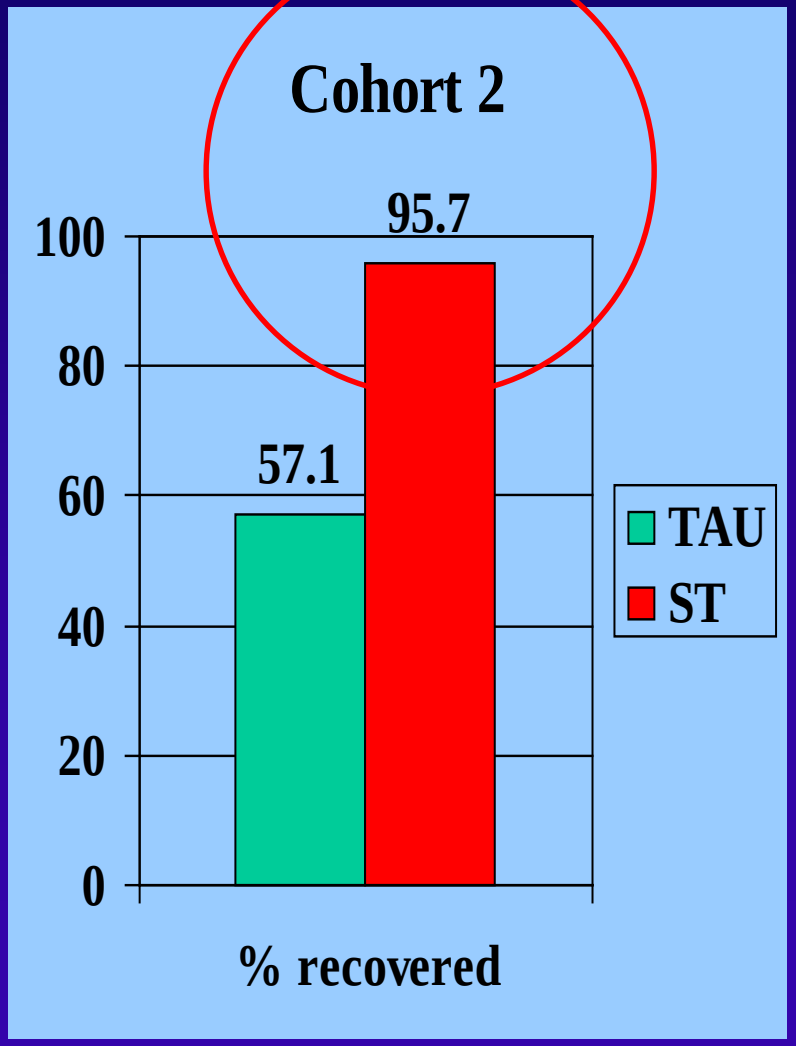


Drop out % from indicated treatment
(mixed log regression estimates)



% Recovered by cohort





Training in and application of ST-techniques matter !

Conclusions

- ST: effective and highly acceptable treatment for Cl-C personality disorder
  - Also cost-effective on a societal level
  - And for health care sector
- Training in & application of ST-techniques influence effectiveness
- Group-ST increasingly popular
  - Catalyzes change processes?

Conclusions - 2

- What makes ST specifically effective?
  - Mode model offers meta-cognitive understanding
  - processing (traumatic) childhood experiences (~ PTSD: trauma-focused CBT > other CBT)
  - Specific therapeutic relationship

    (limited reparenting = corrective experience)
  - Focus on behavioral change later in treatment
    - Push for societal participation and healthy relationships

Thank you !

Recommended literature

Arntz A. (2012). Schema therapy for cluster C personality disorders. In: Van Vreeswijk et al. (Eds.) *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research and Practice,* pp. 397-414. Chichester: Wiley-Blackwell.

Arntz, A. & Jacob, G. (2012). *Schema Therapy in Practice*. Chichester: Wiley.