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SCHEMA-FOCUSED COGNITIVE THERAPY FOR COMPLEX LONG-STANDING PROBLEMS: A SINGLE CASE STUDY

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Abstract. A single case study of a schema-focused cognitive therapy approach to treatment of a young woman with long-term interpersonal relationship problems and affective instability is described. There have been few accounts of this type of therapy that have incorporated outcome measures. Measures of mood and of schema have been taken throughout treatment and results would appear to offer some support for schema-focused cognitive therapy.

Keywords: Cognitive therapy, schema-focused, schema change, complex problems.

Introduction

Cognitive therapy, as developed by Beck (1976), was based on his observation that depressed patients were consistently biased towards negative interpretations of their self, environment and future. This led to treatment focused on helping them to modify their distorted patterns of thinking. It was hypothesized that patients' vulnerability to their present problems could be traced to core beliefs and assumptions that had been laid down in earlier life. Initially, cognitive therapy focused on depression, later widening to include many other disorders. It has been relatively recently that cognitive therapists have begun to move away from treating Axis I disorders to treating more chronic complex problems. As these patients often do not have readily identifiable problems to focus on, and as they often have long-standing dysfunctional interpersonal relationships, standard cognitive therapy techniques may need to be modified when working with this client group. The difficulties in applying standard CT to this group led to a model of CT called schema-focused therapy (Young, 1994a). Schema has been defined (Segal, 1988) as ''organized elements of past reactions and experience that form a relatively cohesive and persistent body of knowledge capable of guiding subsequent perception and appraisals''. Young proposed a subset called early maladaptive schemas, which he defines as broad, pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated through one's lifetime. Treatment's main emphasis is on these. Although this approach was described as far back as 1990 (Beck & Freeman, 1990), there is still a need to evaluate the approach as

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there is an increasing emphasis on the part of purchasers towards evidence-based practice and there has been little in the way of treatment reports supported by outcome data. One such case was reported by Cooper (1994) using cognitive behavioural therapy with a patient who suffered repeated depressions and suicide attempts. Outcome, as measured by the BDI, was very successful. This single case study focuses in more detail on the schema-change methods (Padesky, 1994; Young, 1994a) that proved helpful in giving the patient a framework for understanding her difficulties and in overcoming them.

Background

(All names and some life circumstances have been changed to protect confidentiality.) Claire was a 29-year-old single woman who had moved to this country about $3^1/_2$ months previously from the United States. She had been referred to the psychiatric services by her GP who was extremely concerned by her level of depression and suicidal thoughts. Psychiatry referred the patient on to Psychology, saying that although she was moderately clinically depressed, the indications were that this was more of a personality problem. The patient had been given many drugs in the past, had received little benefit from them, and preferred to have psychological treatment to help her understand her difficulties. She had been first admitted to hospital in 1984 at the age of 20, was diagnosed as suffering from manic-depressive illness and put on Lithium. For the next 10 years, she visited the hospital monthly to have her blood levels monitored. Meanwhile, her problems continued and her difficulty in coping with them escalated until, in 1994, she was re-admitted to hospital for 3 months. At first, she continued on Lithium, and also received ''various sorts'' of counselling, none of it specific or lasting long enough to produce any change. Then her diagnosis was changed to ''dissociative state'', which she resented as she thought that meant that it was all her fault. In her early twenties, she had used alcohol excessively and had taken LSD, heroin and other addictive drugs, but no longer used these and was only drinking a couple of glasses of wine two or three times a week. She had a series of different jobs but did not hold any of them for any length of time. She also had many relationships but none of those lasted any length of time. None of the treatments or counselling she had received had resulted in any improvement in her difficulties.

Assessment

At interview, she was tearful and agitated, scoring at a level of severe depression and anxiety on both the Beck Depression Inventory and the Beck Anxiety Inventory (BDI – 53, BAI – 59) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Beck, Epstein, Brown, & Steer, 1988). She complained of changeable mood, difficulty in coping with day-to-day life, inability to sustain relationships, panic attacks, poor sleep, no appetite and crying for no reason. She spontaneously offered comments such as ''I can't do anything right'', ''I'm stupid'', ''I loathe myself''. She described spending her leisure time lying on her bed, trying to sleep to escape her feelings. When asked to describe those feelings, she was at first unable to do so, but in later sessions was able to describe them as ''that knife-like feeling as if your heart is being ripped open'' and a feeling of being nothing, totally empty. When attempts were made to discuss her early history, she would become tearful and appear to be getting ready to rush from the room. In particular, when asked about her relationship with her father, she

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would become exceedingly agitated. As a result, assessment took several sessions. The preliminary formulation was that a history of emotional abuse by father and lack of support and affection from her mother had led to the formation of negative self-schemas, which had resulted in mood swings, inability to hold onto relationships, a succession of jobs well below her potential, and self-destructive behaviour. Later, a history of sexual abuse by her father on a few occasions was also revealed and subsequently added to the formulation. It was not felt useful at this point to make a formal Axis II diagnosis, partly as treatment was intended to be formulation-based and partly as such a diagnosis often creates a stumbling-block to access to treatment. However, Claire would have met criteria for Borderline Personality Disorder on the grounds of her unstable relationships, impulsive and sometimes self-damaging behaviour, affective instability, chronic feelings of nothingness and constant efforts to avoid real or imagined abandonment.

Early history

Claire was adopted by her parents after they had tried unsuccessfully for 18 years to have a child. One year later, they had her younger brother, James. She was always aware that she was adopted, and says that she was also aware that her brother was the favourite. In spite of this, she described their relationship as best friends. They were brought up on a farm. Her father was very strict and treated both children very harshly. Their mother never showed affection towards either child and did not stand up for them against their father. Claire felt very protective towards her brother and they had a very close relationship — almost an alliance against the parents. They used to escape to their own secret places in the countryside around the farm and stay out of the way as much as possible. Claire was constantly criticized by both mother and father and made to feel that she could not do anything right.

A few examples will give an idea of the atmosphere of the family home. Claire was afraid of the dark and, if the children misbehaved, they were shut up in an outside coalhouse by their father, sometimes together, sometimes alone. They raised chickens on the farm, and she remembers a chicken pecking at her father as he passed and he pulled it out of the cage and smashed its head against a pole. She felt he was capable of doing the same to her. On another occasion, when her young brother had knocked over and broken some eggs, her father picked up James and threw him into a tree where he had to stay all day until their mother came home and took him down. Although the family were fairly affluent (e.g., had the first car and the first TV set in their area), the children always had very little in comparison with other families in the area. They had few toys, rarely had new clothes, had the cheapest of food for their school lunches and were teased by their school mates because of it. The first time they experienced what ‘‘a proper family life’’ could be like was when they stayed briefly with some neighbours when the family moved to a new farm and the parents were working on getting it ready. They had ‘‘real food’’, shoes warmed by the fire, home baking and, most important of all, were shown real affection.

Although their father was the more aggressive parent, it seems that Claire got little in way of support from her mother. She says that neither parent seemed to think a lot of anything she did. They criticized the way she looked, dressed and wore her hair. If she did chores around the house, she was criticized for making a mess; if she did not do them, she was lazy. She was criticized for being too quiet and criticized for being too noisy. Every

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day on her way home from school, she would feel a physical sensation of fear start in her stomach, although this was not as pronounced when her father was not going to be at home. Around the age of 13, she started being picked on at school so had the same feeling of fear in the playground as she had at home.

There also had been some instances of sexual abuse by her father around the age of 10 to 12 that took the form of inappropriate touching and kissing. (Therapy was more than half-way through before Claire felt able to reveal this, fearing that the therapist would think badly of her.) Claire was very confused by this unusual attention, especially as after a few incidents, he went back to ignoring her. However, she continued to fear that it would happen again. When she was 14, her father left home to live with another woman, leaving the two children with her mother. Claire actually found this a relief. However, life was still not easy as her mother, always unable to show affection and always highly critical, now had more of her own problems. From then on, Claire started to rebel against everything — mother, teachers and the counsellors whom she was sent to see. ''I had been desperately unhappy for so long that it became too much for me to care. Then I wanted to hurt everybody.'' She describes this period as being ''hell-bent on my own destruction''. She left school and took a succession of low-responsibility jobs that were well below her capabilities. She had a relationship with a drug-dealer, went to live with him and started trying various drugs, including heroin. She ended up in hospital having taken a drug overdose that she says was accidental. She subsequently left him and then went from one unsuccessful relationship to another, taking this as further evidence that no one could ever love her or want to stay with her. Finally, she moved to England in 1994 where she got a job in a pub as a barmaid.

Treatment

Claire was seen for 15 months approximately weekly, 6 months fortnightly and monthly for 8 months. This was followed by six 4-month follow-ups, making a total of 73 sessions over a period of 3 years, 6 months. We subsequently also had a one year follow-up session.

Progress and outcome measures

Beck Depression Inventory (BDI) (Beck et al., 1961); *Beck Anxiety Inventory (BAI)* (Beck et al., 1988). Initial scores on these (BDI – 59, BA – 53) reflected a severe level of depression and anxiety.

The Schema Questionnaire (Young & Brown, 1990/1994). At session 6, Claire had been given the Schema Questionnaire and scored 100% on most of the schema domains — emotional deprivation, abandonment, mistrust/abuse, social isolation, defectiveness, social unacceptability, failure, dependence, vulnerability, subjugation, self-sacrifice and unrelenting standards. The only really low score, as one might expect, was on entitlement. This questionnaire was repeated mid-treatment, post-treatment and at follow-up (see Figure 1.).

Agoraphobic Cognitions Questionnaire (Chambless, Caputo, Bright, & Gallagher, 1984). This is an 18-item inventory that measures the cognitions that preoccupy individuals in a panic situation. Items are rated along two dimensions: how frequently the thought occurs (1–5) and how far they believe the thought (0–100%). This was given at the start of treatment as Claire was experiencing frequent panic attacks. She rated many of the items highly for both

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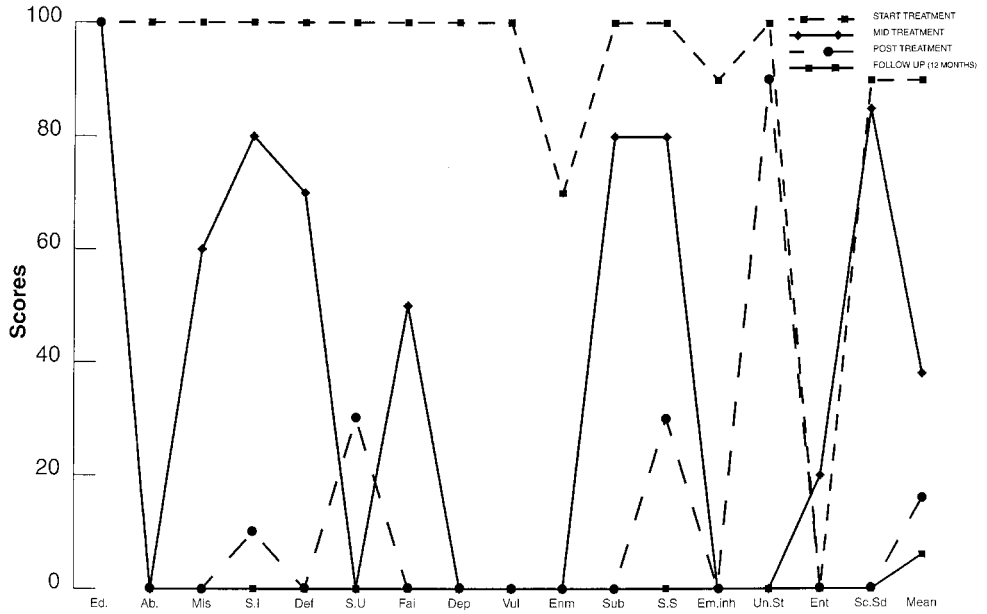


Figure 1. Schema questionnaire scores (%)
Key Abbreviations: Ed: Emotional Deprivation; Ab: Abandonment; Mis: Mistrust/Abuse; S.I.: Social Isolation; Def: Defectiveness; S.U.: Social Undesirabilty; Fai: Failure; Dep: Dependence; Vul: Vulnerability; Enm: Enmeshment; Sub: Subjugation; S.S.: Self Sacrifice; Em.Inh: Emotional Inhibition; Un.St: Unrelenting Standards; Ent: Entitlement; Sc.Sd: Self control/discipline

frequency and level of belief, such as ''I will not be able to control myself'', ''I am going to go crazy'', ''I am going to scream''.

The Social Cognition Questionnaire (Wells, Stopa, & Clark, 1993). A 22-item inventory on the same model as the Chambless Inventory, but the cognitions rated are those of individuals made anxious by social situations. All of these items were rated at the top end of the scale for both level of belief (90% and 100%) and frequency (thought always occurs). Items included ''I am weird'', ''People will think I am stupid'', ''I am unlikeable'', ''I am ugly''.

Medication

When Claire was first seen, she was on 20 mg. Paroxetine per day. As this was not helping to reduce her problems, she was changed to Gamanil after about 4 months. Claire was unable to tolerate the side-effects of this, so her medication was switched to Prozac, 20 mg. a day. This enabled Claire to keep functioning, but in no way removed her problems. She was maintained on this dosage for a further 21 months until the end of active treatment. At that point, she requested that she come off medication, spent a few weeks on a reducing dosage, and had no further medication during the follow-up period (2 years).

First treatment session

Claire presented as severely depressed and anxious. Throughout the interview, she was tearful, agitated and expressed feelings of hopelessness. She found it too distressing to talk

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about anything relating to her family life, and sat perched on the edge of her chair as if poised for flight throughout the whole session. It seemed likely that there might be difficulties in engagement with this patient arising from a difficulty in building trust, the extremely high affect and the distinct possibility that if treatment sessions became too distressing, she might simply drop out. It has been recognized that in patients with long-term personal difficulties that schemas get activated within the therapeutic relationship (Young, 1994a; McGinn & Young, 1996). This presents opportunities to challenge the schema but at the same time can disrupt the therapeutic relationship.

Early treatment

Although Clare was obviously finding participating in treatment difficult, she was highly motivated to try to do something about changing her life. Between most sessions, except when very depressed, she was conscientious about trying to do homework. (She said later that she felt that this was her last chance.) Her mother was about to visit from the U.S., causing her a great deal of anxiety about measuring up to what her mother would expect of her while recognizing that she would not be able to please her. Her other main concern and item for the agendas was the state of the relationship with her current boyfriend. Some details about her early life began to emerge, but each time we started talking specifically about her relationship with her father, she would become extremely distressed and refuse to go on. On one occasion, she began to hyperventilate dramatically and the rest of the session had to be spent in calming her down. On that occasion, it seemed likely that she might not feel able to come back. However, she did and we worked out some ground rules to help her to continue with therapy without continuing to feel distraught for the next 24–48 hours. For example, she could signal within a session when she felt unable to continue with a particular topic, or identify what coping strategies had helped her in the past or use grounding techniques. Each time that the therapist tried to establish a collaborative formulation with her, she became so upset that it was abandoned, so it was not until session 19 that it was possible to complete a formulation (Figure 2). It seemed possible that, in view of her extreme reactions to talking about her father, sexual abuse may have taken place. This was only confirmed half-way through treatment after Claire had hinted on several occasions that she had something she wanted to talk about but was worried that the therapist would think less of her.

Standard cognitive therapy

Treatment initially focused on building a good therapeutic relationship with Claire and socializing her to the cognitive model. She very readily understood the thought/emotion/behaviour connection. Work was begun on identifying and challenging negative automatic thoughts. Progress along these lines was very slow as Claire could readily come up with a rational response, but the outcome ratings were hardly changing at all because her core beliefs were so strong. She could intellectually see that the rational response made more sense, but would say that it did not *feel* that way to her. For example, it was session 23 before she had a belief rating in the outcome column that was less than 50%. As early sessions concentrated on symptom relief, time was spent on the cognitive model of panic attacks, and on trying to increase her activity by means of an activity schedule as well as

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Early experiences
Lack of affection/approval from both parents
Fear of father's violent temper
Brief period of sexual abuse by father
Lack of feeling of safety and security
Material deprivation leading to being made to feel ''second class'' by other children
↓
Core beliefs
I'm no good
I'm unlovable
Nobody wants to be with me
The world is a dangerous place
You can't trust anyone
Whatever I do is never good enough
↓
Dysfunctional assumptions
If I let people get close to me, they won't like what they find
If I let them get close, they will only let me down
Once others really know me, they reject me
Unless others show me 100% approval 100% of the time, they are rejecting me
If people say nice things about me, they don't really mean it
↓
Critical incidents
Any criticism (real or imagined)
Any rejection (real or imagined)
People expressing affection towards me
↓
Compensatory strategies
Choosing partners who are unobtainable in some way
At slightest negative sign, reject them before they can reject you
Keep something back in relationships
↓
Negative automatic thoughts
I can't do anything right
Mark won't want to stay with me
I've wasted mother's time this trip
I'm not achieving anything with my life
↓
Symptoms
Behavioural — avoiding social situations, being possessive, jealous
Motivational — lack of enthusiasm, no pleasure in anything
Affective — depressed, anxious, agitated, tearful, guilty
Cognitive — selective attention to negative things about self
Somatic — sleep problems, loss of appetite

Figure 2. Cognitive-behavioural formulation for Claire

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keeping her thought diary. She was lent a copy of *Feeling good* (Burns, 1981) and read this assiduously, coming back with a lot of questions about the ideas in it. However, it was quickly apparent that more long-term and in-depth work was going to be necessary to help Claire to bring about some change in her life.

Schema-focused treatment

At session 8, Claire was introduced to the idea of schema work, which she was eager to try as she was finding it hard to successfully challenge her negative thoughts. After completing the Schema Questionnaire, she was given *Reinventing your life* (Young & Klosko, 1994) to read which she found very relevant to her problems. It was also a great relief (and surprise) to her that others had similar problems as she had always considered herself to be weird and different. In addition to building a formulation, various interventions were employed to bring about some change in her beliefs.

Schema diary sheets and flashcards (Young, 1994b, 1996)

Claire was encouraged to use schema diaries and flashcards. These she found useful to help her identify why she was over-reacting and misinterpreting things, and to start trying to step back from an instant automatic response. After completing a number of these in similar situations, she would work out a general rule for these situations and transfer it to a schema flashcard, an example of which can be seen in Appendix 1.

Self-esteem work

The idea of this was introduced to her using the prejudice model (Padesky, 1990), which seemed to be the first intervention that opened up the possibility for her that her beliefs about herself just might be wrong. Various methods of working on rebuilding a more adaptive schema were introduced such as a positive data log, making a list of good things about herself (which she found incredibly hard) and using a knitting-needle stitch counter to total good thoughts about herself during the day at work when it was difficult to have the privacy to write these things down. Later on in therapy, when Claire entered a stable relationship, her partner was also able to provide her with evidence for the new schema.

The use of continua (Padesky, 1994)

At first, Claire's estimation of her own worth was so low (0%) that she found trying to do any continuum work greatly distressing. Even asking where she would put such figures as Hitler failed to shift her off the 0% mark. She would become tearful and want to do something else because her belief that she was worthless or nothing was so strong. After several attempts, by session 38 she was able to tolerate doing criteria continua. This involves asking the person to rate herself on a desired schema continuum. Then the criteria for the desired schema are listed in perfect terms under the 100% rating and the complete absence under the 0% rating. Then a rating for each of these criteria is completed, which can provide the basis for further learning on the part of the patient. The criteria selected by Claire as being elements of self-worth included ''smart, conscientious, hard-working, gets on easily with

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other people and willing to get involved''. Her overall assessment of her worth by then was 30%. Claire was surprised to find out that the average of the criteria continua was 65%. The change in her beliefs, as one might expect from her history, was very slow. By session 49, she was still saying that her beliefs were unchanged but that at least she now believed that they could be changed.

Historical challenge of schema (Padesky, 1994)

This took up several sessions with Claire also working on it for homework. Information was gathered in three columns: a) evidence supporting this belief; b) a column headed ''But'' which gave the opportunity for her to cognitively restructure the events in the first column; c) evidence against this belief. The belief Claire wanted to challenge was ''I am nothing, I am worthless''. A sample extract from her historical challenge is shown in Table 1. In addition to the historical challenge, another way of assisting Claire to reframe her early experience was writing a letter to her father (not to be sent). She had found it too difficult emotionally to try within session saying what she would have liked to have been able to say to her father, but was able to write a letter in very moving terms that described her emotional pain about her childhood and how she felt he ought to have behaved towards her.

Preparation for termination and relapse prevention

Since the beginning of treatment, Claire had expressed anxieties about the therapist ''getting fed up'' with her or deciding that she was wasting the therapist's time. Any event that she perceived as bringing the end of treatment closer (such as the therapist moving to a different job or a drop in the frequency of her session to fortnightly) brought an escalation of anxiety that was reflected in her BAI and BDI scores. Care was taken from the start to emphasize the fact that the aim of cognitive therapy was to enable the patient to become their own therapist and that all therapeutic relationships come to an end. Although extremely anxious about this initially, Claire was eventually able to move towards this, and even to start taking the initiative in suggesting a move to increasing the interval between sessions. Small flashcards that could be easily carried in a handbag were developed to help her keep challenging the old schema. A summary of therapy and a blue-print for the future were developed (Appendix 2).

Interim progress

Around mid-treatment, Claire had become dissatisfied with her job and with her employer (an alcoholic) and had begun to think it was time to try to find herself a better job. She was now 30 and feeling that she should have something more to show for her life than she had at present. She had already started a word-processing course, and now decided to apply for a secretarial-cum-receptionist post and was accepted. Immediately, she was assailed by doubts that she would be able to cope with it and to live up to other people's expectations of her. She found the first few months in this job quite stressful, but gradually gained a little confidence about her abilities, though this was extremely fragile and easily demolished by any criticism, real or imagined. Also at this time, after a series of relatively short-term

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Table 1 Historical challenge of schema belief: I am nothing, I am worthless.

Evidence supporting the belief	But	Evidence against the belief
0–5 years		
I was never important My brother got all the attention — I was only the background My fears and beliefs were not worth discussing or comforting I was always aware I was less special	It was understandable that my brother got more attention than me because first they thought they couldn't have any children, then he nearly died, but my mother should have made sure that we both felt equally special.	My relationship with my brother I was important to my grandparents My aunt and uncle used to stick up for me I had an affectionate relationship with both my grandparents and my aunt and uncle
The neighbours did not like me	That was because of their relationship with my parents.	
5–8 years		
I used to go to a 10 yr old baby-sitter who stuck pins in me. Even though I used to get upset about going, I was still made to go.	That is a reflection her, not me, and Mother probably didn't know what was going on.	
I wasn't very popular at school. People called us ''scabs''. We never had any money for things. Everyone had cling-wrap on their lunches — we had to have greaseproof paper. Others had nice white rubbers, we had to have cheap grey ones. Others covered their books with pop-stars, we had to have plain brown paper.	Yes I was unpopular, but I did not get the chance to fit in with the other children because of my parents.	A cleaner at school took time to teach me how to spell.

relationships, she met Colin who is now her husband. At first, this relationship caused her many of the same doubts and over-reactions as previous relationships had done. Gradually, she came to accept that it really was possible for someone to love and appreciate her, and who perhaps could be trusted though it took a long time to get to that point.

End of treatment

Gaps between sessions were first stretched to monthly and then to 4-monthly follow-ups. Claire was by then much more adept at challenging her negative thoughts, recognizing the pitfalls of her old schemas, and working towards constructing a more realistic schema. She began to have glimpses that it might be possible that she just might be good at her job and be valued by her employer, and that in her personal life, others might value her as a friend,

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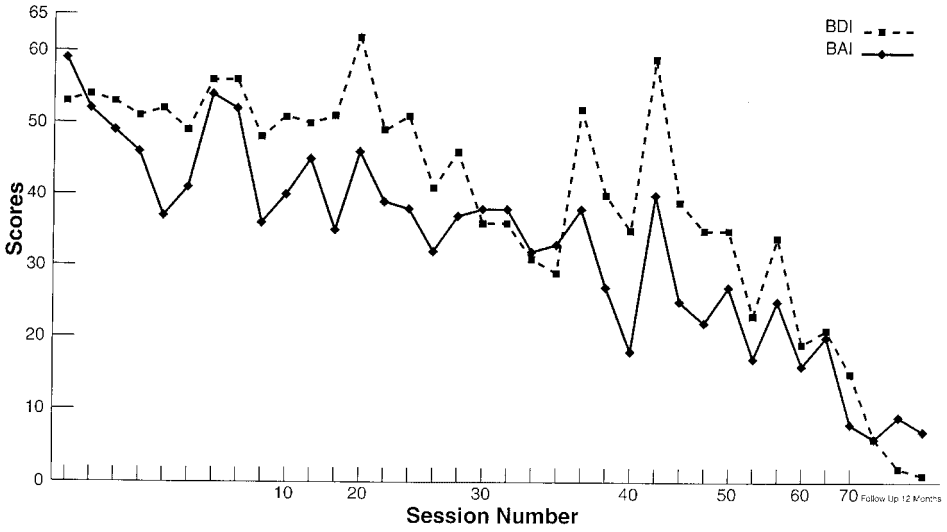


Figure 3. BDI and BAI scores

seek her company and even love her. During the follow-up period, she and Colin decided to get married. She also decided to look for another job as she felt she had done all she could in her present one, which represented a considerable change in her beliefs about her own abilities. She met Colin's family whose affection and approval provided her with further evidence for her new beliefs about herself. She said that she at last felt part of a proper family. The last of these follow-ups was timed to be in the week before her wedding. At that time, her BAI was 9 and her BDI was 2, and she was permitting herself some optimism about her new life.

One year later, at final follow-up, Claire had maintained progress (a BAI of 6 and a BDI of 1). Her marriage was working out well. She had a new job as personal assistant to a company director with a great deal of responsibility and was highly thought of. She described herself as much more confident though occasionally prone to self-doubts. When this happened, she was able to challenge her negative thoughts, or use other techniques to cope with the problems in a relatively short time. Her mother had been back to stay with her, and although her critical attitude towards Claire had not changed, she was much better at dealing with this. She recognized that she was not at fault and that she has to accept that her mother will never be able to provide her with the sort of nurturing relationship that she would have liked to have. Colin has proved to be a very supportive partner who has been helpful in overcoming her problems. She summed up ''I feel I have got my life back now''.

Outcome data

On measures of mood (BAI and BDI), Claire showed quite extreme fluctuations at first (Figure 3). These were precipitated by incidents that activated Claire's schemas relating to unworthiness and rejection. For example, the peaks at sessions 7 and 8 coincide with her mother's first visit to the U.K. and at 44 with her second visit. The next at session 21 was triggered by reading the chapter on emotional deprivation. The rise at session 37 was related

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to being told of the therapist's move to another post. In spite of the fact that she was assured that her therapy would continue with the same therapist, she was initially unable to believe this, assuming she was going to be let down and rejected yet again. Gradually her scores reduced to normal levels at end of treatment (BAI 6, BDI 1) and were maintained at 12-month follow-up.

The Schema Questionnaire was repeated at mid- and post-treatment, and at 12-month follow-up. These scores reflected a marked decrease over time (Figure 1) in her negative beliefs about herself. One aspect of her profile that deserves comment is her score on emotional deprivation. This was the only score that did not reduce as treatment proceeded. The reason for this appears to be that all items in it are phrased in the past tense. Therefore, no matter how well Claire becomes, the score will stay the same as the fact that this abuse happened does not change. As an experiment in the follow-up session, Claire was asked to complete that section again but this time changing the wording of the items to the present tense. This time her score was 0. This might suggest a closer look at the wording of the items in this domain as it is the only one dependent on past history rather than present beliefs and assumptions. Scores on both the frequency and belief sections of the Agoraphobic Cognitions Questionnaire and the Social Cognitions Questionnaire had reduced by about 50% by mid-treatment, but these were not repeated at end of treatment or follow-up.

Discussion

Criticisms could be made of some aspects of this case report. Had a therapist from another theoretical standpoint been treating this patient, it is probable that a different formulation may have evolved. However, this collaborative formulation made sense to both patient and therapist of what was maintaining her problems and what had produced a vulnerability to them in the first place. From her own statements, it appears to have been a large part of establishing treatment credibility with her and the treatment implications derived from it appear to have been appropriate. Another criticism might be of the length of treatment. Obviously, it is not often in the current financial climate of Mental Health Trusts that it is possible to offer so many sessions and it could be argued that such a large number of sessions cannot be justified for one individual. However, in view of the patient's extremely abusive family history, it is not surprising that long-term therapy was necessary. As is common with this type of patient, a considerable number of the early sessions were spent in establishing a good therapeutic relationship, without which little progress could have been made. It was also decided that spaced booster sessions would help her reduce the need for that relationship and gradually take more responsibility for her continued progress. When one takes into account the degree to which mental health resources had already been involved in her country of origin, and the fact that she would probably have continued to be a high user of resources in this country, long-term therapy is likely to have been a cost-effective option. In spite of the initial severity and chronicity, and by implication poor prognosis for change, there were other factors that influenced the outcome of treatment in a positive way. Claire had come to a point where she felt she had to make changes in her life and was highly motivated to try to bring those about. As mentioned above, when asked on the last session to identify which aspects of treatment had been most helpful, she replied that having a formulation of her problems gave her a framework to understand why she thought, felt and acted in the way she did. Up to that point, she had no understanding of

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her problems, of why she felt so bad about herself, and thought that there was no hope of things changing. The formulation gave her both an explanation and a glimmer of hope. Another important aspect of treatment she identified was the therapeutic relationship, also referred to above, which gave her the necessary support to be able to test out her beliefs and assumptions and find they were disconfirmed. It was important for her to be able to form a relationship based on trust. It may also have been important that after postponing the disclosure of sexual abuse for so long for fear that the therapist might lose her regard for the patient, Claire found that it made no difference. It would have been interesting to have included a measure of the therapeutic relationship but that was not done.

Conclusion

A combination of standard and schema-focused cognitive therapy was successful in treating Claire's problems, and she maintained her progress through 15 months of follow-ups and a final one-year follow-up. This case appears to offer some support for schema-focused cognitive therapy. However, there is a need for more case studies using clearly described procedures, routine measures and evaluation of outcome and, in spite of the longer time necessary to treat complex cases, a need for larger trials.

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Appendix 1. Schema therapy flashcard

1. Acknowledgement of current feeling

Right now I feel _____ *rejected* _____ because
(feeling)
_____ *Mark has said something that makes me feel he does not care* _____
(Event which triggered feeling)

2. Identification of schemas

However, I know that this is probably my _____ *emotional deprivation* _____ schema(s), which lead me to exaggerate the degree to which _____ *I need constant reassurance that people value me* _____

3. Reality testing

Even though I feel _____ *rejected* _____

The reality is that _____ *I misinterpret the situation because I find it hard to believe that people value me* _____
(alternative explanation)

4. Behavioural Instruction

Therefore, even though I feel like _____ *crying, losing it, ignoring him, getting angry and shouting* _____

I could _____ *pause to think about the situation before reacting, and remind myself that I am probably over-reacting again* _____
(alternate behaviour)

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Appendix 2. Blueprint

What have I learned (ideas, techniques, facts) that has been helpful?

— Starting to realise the things I was told about myself when young were not necessarily true, and parents were not always right
— being able to talk back to negative thoughts
— using schema diary sheets to pin down why I was over-reacting — helped me to think differently
— collecting good things about myself challenged the old core beliefs
— realising I let any negative things about myself, however tiny, outweigh anything else
— realising my ideas about myself were like a prejudice, and it takes lots and lots of evidence to change a prejudice
— understanding my mother, that she acts towards me in a way which disappoints me, but it's not her fault and it's not my fault — it's just the way she is
— the knitting-needle counter, being aware of good things about me, seeing light at the end of the tunnel

How will I carry on using these things in everyday life?

— if I start to feel less good about myself, restart good things diary or use counter
— set aside an hour to an hour and a half once every week or two weeks to do some self-therapy — a beautician's time for the mind!
— if circumstances start mood sliding, use thought diaries or schema diaries for a few days

What might make it difficult to do this?

— getting too tired to do it

How would you overcome this difficulty?

— managing time better would help

What might cause a setback?

— any situation which makes me feel disappointed in myself
— taking something Colin says way out of proportion (when it is a personal comment)
— any situation which could be interpreted as rejection (mother and boss can both do that)

What would you do if you had a setback?

— use schema sheets
— go over our notes again
— re-read chapters from ''Reinventing your life''
— last resort, call therapist.

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