Chapter 6
Schema Therapy for Problem Gamblers

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CBT remains the most effective treatment for PG (PGRTC 2011). Yet, scope remains for improvements to both the short- and long-term effectiveness for treatment-seeking PGs (Rickwood et al. 2010). Alternative or adjunctive treatments to CBT should be considered to address the above treatment effectiveness gaps. This chapter explores schema therapy as an adjunct to CBT for PG.

What Is Schema Therapy and Why Might It Be Helpful for PGs?

Schema therapy was originally developed by Jeffrey Young (1990, 1999) to treat patients with characterological problems that manifested in entrenched, chronic psychological disorders that did not respond to traditional CBT. Blaszczynski and Nower's (2002) Pathways Model identified anti-social personality traits as forming one of the three routes into PG, suggesting a role for schema therapy for those members of the PG population whose anti-social personality characteristics led to and maintain their PG.

Recently, the schema mode approach (SMA) has expanded traditional schema therapy. Young defined early maladaptive schemas (EMSs) as self-defeating cognitive and emotional patterns that begin early in development and repeat throughout life (Young 1990, 1999). He defined schema modes as a set of currently active schemas or schema operations that can be adaptive or maladaptive (Young et al. 2003). These modes can be persistent or shift frequently, are divided into mostly

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negative emotions, and other modes may be developed and used to cope with the negative emotions. SMA asserts that these modes may be more effectively identified and changed than the underlying schemas (Arntz and Jacob. 2013).

SMA provides an appealing heuristic for explaining the maintenance of PG behaviour, particularly for patients whose symptoms persist despite actively completing CBT for PG programmes. We believe that SMA may also be appropriate for patients presenting via the emotionally vulnerable as well as via the anti-social personality disordered pathway (Blaszczynski and Nower 2002). Our anecdotal experience suggests that the SMA heuristic is well accepted by PGs and the ensuing treatment has been effectively deployed to a small number of PGs in our clinic. Robust research on SMA approach for PG is the next step.

What Is Schema Therapy?

CBT was described by Young et al. (2003) as being based on the following assumptions that limited its usefulness for entrenched, chronic psychological disorders: patients are motivated to build skills, complete homework and solve problems and are capable of change with prodding and positive reinforcement, and they will comply with treatment protocols; patients can access cognitions and emotions and report them easily to the therapist; cognitions and behaviours will change via empirical analysis, experimentation, logical discourse and repetition; patients have a degree of psychological flexibility that allows them to respond to treatment in a relative short period of time; the therapeutic relationship is established early and easily and is not a focal ingredient of treatment.

As clinicians treating PG know, treatment-seeking PGs do not always act in a way that is consistent with the above descriptions. PG can present as entrenched, resistant over longer periods to CBT treatment, and is sometimes formulated to be a response to intense emotional distress that has origins earlier in patient's lives than when they present for treatment. Schema therapy has obvious appeal for treating such PGs given its focus on reducing the impact of childhood and adolescent origins of psychological problems and that it is now seen as flexible to patient needs in terms of the length of time in treatment (Young et al. 2003).

Early Maladaptive Schemas

Young (1990) proposed a classification system of common schemas that underlie individual psychopathology. To this end, he developed the Young Schema Questionnaire (YSQ; Young 1990; Young and Brown 2001) consisting of 205 items that attempted to assess 16 core themes thought to be common to psychopathology. Subsequent research has resulted in a further two schemas being identified and a

Table 6.1 Early maladaptive schema domains and early maladaptive schemas

EMS domain	EMS
Disconnection and rejection	Abandonment/instability; mistrust/abuse; emotional deprivation; defectiveness/shame; social isolation/alienation
Impaired autonomy and achievement	Dependency/incompetency; vulnerability to harm and illness; enmeshment/undeveloped self; failure
Impaired limits	Entitlement/grandiosity; lack of self-control/self-discipline
Other-directedness	Subjugation; self-sacrifice; approval seeking
Hypervigilance and inhibition	Negativity/pessimism; emotional inhibition; unrelenting standards; punitiveness

Table 6.2 Early maladaptive schemas (Arntz and Jacob. 2013)

EMS domain	Basic need
Disconnection and rejection	Safe attachment, acceptance, care
Impaired autonomy and achievement	Autonomy, competence, sense of identity
Impaired limits	Realistic limits, self-control
Other-directedness	Free expression of needs and emotions
Hypervigilance and inhibition	Spontaneity, playfulness

shortened 90-item version (YSQ-SF; Young 2005) that has returned respectable validity (Scott and Crino 2014). The 18 EMS currently identified are listed in Table 6.1 (from Arntz and Jacob 2013).

Early maladaptive schemas (EMSs) are believed to develop when basic childhood needs are not adequately met. The resulting dysfunction takes the form of restrictions on recognising, fulfilling and experiencing needs in later life. Both the EMSs themselves and the processes that have formed in childhood to adapt to the absence of the needs being met are thought to contribute to dysfunction. For example, a child whose parents separate in acrimonious circumstances may fail to have their attachment, security and safety needs met. Later in life, difficulties with stable relationship forming and coping strategies including prematurely ending relationships due to perceptions of mistrust may occur.

The basic human needs as defined by Young et al. (2003) fall into five groups, each mapping to an EMS domain. Both the EMS domains and the basic needs were developed from clinical observation rather than strict experimental designs, explaining why new EMSs have been identified and added to the schema therapy model over time. Current EMS domains and the corresponding unmet human needs are set out in Table 6.2.

Although the identification of an individual's EMS is best obtained by clinical observation/judgement, there are a number of instruments with reasonable psychometric properties that can be used to supplement that process. The YSQ-SF (Young 2005) and Schema Modes Inventory (Lobbestael et al. 2010) are our preferred 'user friendly' instruments given their validity and lower patient burden than the original YSQ.

What Is the Schema Mode Approach?

Many PGs report that they are unable to explain 'what comes over them' in the period before and during their disordered gambling. For example, patients have reported to us that they 'lose their mind' and that they engage in gambling even though they understand the odds of them winning are very low. They also report recognising that the damage they are exposing themselves to in terms of interpersonal conflict, financial distress and unhealthy behaviour likely has long-term consequences. The 'felt' or emotional experience that accompanies the period prior to and during gambling activities can be under-explored in CBT, when conceptualising that process as automatic or if focused on primarily cognitive functions. These experiences may better be conceptualised for some PGs as reflecting the operation of schema modes.

Originally developed by Young et al. (2003) and developed further by Lobbestael et al. (2009), the schema mode approach seeks to explain the psychological distress arising from the conflict between different 'parts/sides' of an individual. SMA sees current triggering situations as activating a very specific memory or memories associated with an intensely distressing emotional experience, from a key developmental period, similar to the maintenance of a trauma memory network (Foa et al. 1989; Brockman and Calvert 2016). Contemporary attempts to respond to the psychological distress created by the triggering situation are sought from representations of key developmental figures that were present earlier in life (parent modes) or via the cognitive processes available to the patient at the younger age (child modes).

In addition to the development of the parent and child modes, an individual may activate schema coping modes to provide the best working solution to the distress they are experiencing. Reinforcement, for example in the form of reduced distress, may serve to further embed the validity of the mode(s). The operation of the mode pattern is a poorer substitute for one or more of the childhood needs not having been met. The schema coping modes may be accompanied by lower levels of emotional intensity than the other modes. Unlike the other modes, the reported 'felt' age of the individual when they are experiencing the coping mode tends to be aligned with their actual age rather than the age at which the unmet need presented as initially being problematic (Arntz and Jacob 2013).

The schema coping modes are believed to fall into three distinct categories. Individuals may have preferred or persistent coping styles, or the behavioural and experiential patterns may move, between the coping styles. The three categories of the schema coping modes are:

- Surrender – the schema is taken as accurate and the patient gives in to the maladaptive parts of the schema.
- Avoidance – the situation(s) triggering the schema is avoided to circumvent the intense emotions associated when triggered.
- Overcompensation – acting in a dominant way opposite to the maladaptive parts of the schema.

Table 6.3 Expanded schema modes (Arntz and Jacob. 2013)

Dysfunctional child modes – lonely, angry, abandoned/abused, dependent, enraged, obstinate, impulsive, undisciplined		
Dysfunctional parent modes – punitive and demanding		
Coping modes	Surrender	Compliant surrenderer
	Avoidance	Detached protector; avoidant protector; angry protector; detached self-soother
	Overcompensation	Self-aggrandiser; attention-seeking mode; perfectionistic/overcontroller; paranoid overcontroller; bully and attack; conning and manipulative; predator
	Functional or healthy modes	Happy child; healthy adult

The schema modes have been expanded recently as described below (Table 6.3).

It is very helpful to firstly identify which of the three broad modes is operating within the formulation. Child modes relate to feelings consistent with a much younger age than the patient actually is, such as being overwhelmed, highly stressed or abandoned or experiencing a deep sense of threat. Enraged and impulsive feelings are also possible in the child modes. In gambling patients, a sense of lacking discipline, poor limit setting skills and the absence of an appropriate role model who can process difficult emotional states is common. We have seen both the vulnerable and the angry child modes in our clinic, the latter being associated with 'tantrum'-like behaviour when no other strategy reduces the distressing feelings. Gambling excessively/inappropriately is then used as a fraught way of working around the unmet needs.

The dysfunctional parent modes are characterised by self-hate, high pressure and overbearingness (Johnson et al. 2006). They are distinct from the child modes in that they are secondary and are believed to represent constructions within the patient of their caregiver's morality and behaviour. Punitive parent mode is the common expression of high moral values. The demanding parent reflects high pressure and maintenance of standards to achieve perfection and to do better than others (Arntz and Jacob. 2013). This mode presents commonly in our clinic alongside generalised anxiety disorder.

The schema mode approach allows the therapist to work with the patient to map out the maladaptive process that follows once an EMS has been triggered and to identify adaptive ways in which to get the patient's needs met. SMA involves working in the present, as well as appreciating the times at which the EMS was formed or reinforced. It involves designing effective ways for operating in the future. It is familiar in many ways to CBT treatment and therefore it aligns well as an adjunct to CBT.

What Is the Broader Evidence for the Schema Mode Approach?

SMA has also been reported to reduce symptoms in non-personality disordered populations for psychopathology such as depression (Renner et al. 2016). Depression appears commonly co-morbid with PG (Petry 2005). Whilst no specific research has yet examined the use of SMA for treating PG, support for SMA treatments in broader personality disordered individuals suffering from PG and PGs with mood disorders could be a good initial subset to target. This may be particularly relevant for those patients in the above subset whose recovery is resistant to CBT or for whom CBT does not provide a longer-term positive treatment outcome.

Cognitive and Behavioural Interventions in SMA

Cognitive interventions in PG treatment are typically used to strengthen an individual's understanding of the risk that gambling presents for them, to raise awareness of thinking patterns that are maladaptive and to learn to challenge or accept potentially damaging cycles of thinking that can lead to acting in maladaptive ways. Likewise, behavioural interventions can be very helpful in limiting exposure to high-risk situations and in building constructive patterns for greater wellbeing away from the damaging behaviour. When CBT is delivered in its most narrow form, there is potential for the emotional experience to be examined in a cognitive and logical fashion. The emotional focus of schema therapy is more explicit about emotions, and techniques such as 'affect bridges' and 'limited reparenting' (see below) are used.

Schema Mode Interventions

A number of schema mode interventions that we have used in the treatment of PGs are discussed below using the case study of a patient called Audrey.

Case Study

Audrey was a medical professional who reported gambling extensively for 10 years using online poker machines, often losing her entire fortnightly salary. She reported a number of longstanding interpersonal conflicts with key colleagues at work, and the major gambling events would occur after distressing interactions with these colleagues. She had few social contacts outside of her work, and her marriage had

deteriorated to the point of a divorce 3 years prior to assessment. She presented as highly organised, and she attended with a range of articles she had sourced on PG treatment. She described many examples in which colleagues had breached company conventions and became defensive when her interpretation of events was explored and challenged. Audrey stated that during her teenage years she would focus intently on her studies and would restrict her eating when her standards were not met by herself or others.

Assessment Audrey's YSQ-SF revealed scores of 5+ for items related to unrelenting standards, emotional inhibition (both hypervigilance and inhibition schema domains) and mistrust abuse (disconnection and rejection). These findings were consistent with the clinical evaluation. The assessment revealed Audrey's father left the family when she was 10 years old and moved to another state with a new partner, severing contact for 5 years. Audrey stated that her mother insisted that she always be well groomed when leaving the house and stressed the importance of having a stable career so as to achieve independence. Audrey also reported that she felt most satisfied in life when she worked in research assistant roles where protocols were used for clinical trials. Since the rising to the team leader role 10 years earlier, she had experienced greater conflict and had increased her use of online poker machines which she accessed via her desktop computer at home. We also assessed her childhood unmet needs, EMSs and modes using an 'affect bridge' (see below).

The assessment was completed using clinical interviews over three sessions, and the clinical findings were validated using the following instruments: Young Schema Questionnaire Short Form (Young 2005), Schema Modes Inventory (Lobbestael et al. 2010), Depression Anxiety and Stress Scale-21 item (Lovibond and Lovibond 1995) and the Problem Gambling Severity Index (PGSI; Ferris and Wynne 2001). Homework during the assessment phase consisted of implementing stimulus control measures to restrict access to money and her computer at home, monitoring of urges, behavioural activation and scheduling adaptive behaviours.

Case conceptualisation The case conceptualisation process was iterative over two sessions. The therapist focused on presenting the draft to her after the assessment and validity testing to achieve agreement, consistent with CBT. Psychoeducation about each of the modes, learning theory relevant to PG and CBT-based practices such as accurate information on the chances of winning and benefits of stimulus control were also weaved into the sessions at this time.

In the next phase of treatment, we explained the basic childhood needs (Table 6.2 above) and discussed examples of the dysfunction in the hypervigilance/inhibition and disconnection/rejections schema domains. A further level of detail was then provided in terms of the specific EMSs identified in the assessment. Amendments were made throughout to the case conceptualisation to keep it current and meaningful. Homework activities were set from Young and Klosko (1994) (Fig. 6.1).

SMA psychoeducation The next stage involved a deeper exploration of the formation of the EMSs. 'Affect bridges' were used to make the learnings experiential. The parent and child modes were introduced, as was the distress that she felt when they

Fig. 6.1 Case conceptualisation for Audrey

were activated by a situation in the present. We found it relevant here to tie the 'voices' or instructions these modes delivered to her in distressing times to the relevant mode. For Audrey, the demanding parent voice was easily assignable to her mother and the vulnerable child voice was herself around 13 years of age.

Audrey found the description of the modes more 'palatable' when we referred to them as 'sides' of herself that were in control at different times. Of particular note in Audrey's conceptualisation was the distress she experienced from the interaction of the parent and child modes once the EMSs were activated. We agreed that the tension between those modes was often unresolved and lead to the use of coping modes to relieve the distress.

After two sessions on the parent and child modes, the relevant coping modes were introduced under the broad categories of surrender, overcompensation and avoidance. 'Affect bridges' were used again over a number of sessions so that Audrey developed a cognitive and emotional understanding of the differences between the modes. Healthy adult mode was introduced early in the treatment phase as an effective way of getting needs met. Homework was given throughout to monitor the hardest and best parts of each day, and then for the above conceptualisation to be used to identify which modes were operating at those times.

Audrey was also asked to note more details about the modes as they occurred in her day to day life for homework We were particularly keen for her to focus on the 'felt' aspects, so she developed greater skills recognising the differences between the modes, again in both a cognitive and emotional way. One goal was for her to see the modes as independent 'sides' of herself that could be isolated, identified and explained as states rather than traits.

After Audrey had developed a good working understanding of all of the different modes, further psychoeducation about the limbic system with visual aids was provided. Here we explained the activation of this system as being triggered when contemporary situations aroused distressing memories stored in the hippocampus. Pros and cons of the various modes were worked through to demonstrate that there were positive aspects to each of them, where the limitations existed and what costs were involved in allowing the modes to operate unchallenged. The healthy adult mode was highlighted as incorporating many of the positive aspects of the maladaptive schemas, so change was both desirable and achievable.

Chair work and imagery rescripting After ten sessions, treatment then moved on to using 'chair work' and 'imagery rescripting'. Chair work operates in both the cognitive and emotional-focused treatment domains. This process involved separating Audrey's modes, and over various sessions allocating individual chairs for each mode. In the earlier sessions, only the modes that were being worked upon in that session were allocated chairs, for example, the parent and child modes were isolated to establish the nature of the conflict between those modes, before exploring the coping modes.

The therapist and Audrey took turns either playing the individual modes or interacting with them from another modes' perspective. When 'playing' a mode the relevant person would sit in the chair designated for that mode, and when shifting

to another mode physical movement to the other relevant chair was required. Awareness, acceptance and challenge of the modes were key in chair work, so that Audrey could develop skills in properly identifying and meeting the needs of each mode rather than operating in the dysfunctional automatic way that had caused problems in the past. For example, when the demanding parent mode placed more pressure on the vulnerable child to do better as a means of resolving distress, the needs of the vulnerable child were elicited and advice from the healthy adult mode was sought.

Imagery rescripting (Arntz et al. 2007) was introduced in later sessions to help Audrey address schema-related problems. The use of imagery in CBT is well established (Hackman et al. 2011; Holmes and Mathews 2005; Hunt and Fenton 2007). Audrey was asked to recount a recent distressing situation she had encountered at work. After a brief summary, we asked Audrey to close her eyes, relax her body and try to access the memory of the distressing situation as if she was re-experiencing it. She was directed to put her attention a few moments in time prior to the peak of distress in the imagined scenario. Audrey was asked to explain details of the environment in the first person, and as the detail built, she was asked to explain how she felt. Audrey described her feelings from a factual rather than 'felt' perspective initially, so we slowed down her account and focused on getting more emotional and physical sensations detail about her experience in the scenario. Audrey found it helpful to use metaphors to describe her feelings, for example 'I feel like I'm a trapped and injured animal and the only way for me to deal with this situation is to come out fighting'. Once the emotions and sensations were described in more detail, we helped Audrey move forward in her account and asked her to maintain focus on her 'felt' experience as she progressed to the key point of distress. We also asked her to note any changes she noticed in her emotional experience as she progressed through her account of the past distressing experience. Unlike an exposure and response prevention protocol, we were not trying to elevate Audrey's distress and then to allow habituation, rather we wanted her to activate the schema modes to a level she could recognise their character in a more detailed way.

Once the above was achieved, we asked Audrey to reflect on a childhood memory where she had felt a similar cluster of emotions. The above process is called an 'affect bridge', which helps link the 'felt' contemporary distressing experience to a period earlier in life when the EMS may have been formed. Audrey stated that a memory of her at age 13 presented itself, in which she was frightened because she was not picked up from a hockey training session by her mother after dark. When her mother finally did turn up, she berated Audrey for standing in the wrong spot, breaching a rule about never being alone after dark and that she had put herself at great risk of physical harm and her mother all out of schedule with her own commitments. In the memory, Audrey's mother did not acknowledge her fear and made no attempt to comfort her, rather she increased her distress by blaming her for the situation.

We elicited Audrey's feelings in detail and then asked her to visualise the therapist in the imagined scenario at her house after being driven home by her mother. The therapist then 'rescripted' the memory to facilitate the creation of new and more functional memories. In the new script, the therapist comforted Audrey, and

sought to resolve the conflict Audrey felt about not being able to act in a way that would have met her mother's standards. One goal was to help Audrey feel safe, and to open Audrey's interpretation to the idea that sometimes mistakes occur and searching for the person to blame is often not going to meet anybody's needs. In the image we also spoke to Audrey's mother to try and facilitate learning for her, and the negative consequences that can occur when Audrey's mother's anxiety leads to berating Audrey, rather than teaching her how to stay safe when things go wrong. The focus was on empathetically challenging Audrey's mother about her behaviour so that Audrey's needs of attachment, safety, care and spontaneity and play were met. This process was repeated for a number of distressing memories in which Audrey's needs were not met. Such a process is known as 'limited reparenting'.

Final Comments on Treatment

Throughout treatment, learning to spend more time in the healthy adult mode when triggering situations occurred was a broad goal. The individualised case conceptualisation included the treatment goals: abstaining from gambling, increasing appropriate socialising in healthy environments, completing a physical accomplishment, building relationships with specific family members and pursuing a career objective. These goals helped tie the conceptualisation to the presenting problem. Within the conceptualisation, it was important to set out linkages between the unmet needs, EMSs and the parent/child/coping modes. A balance between working to directly address issues in the conceptualisation and more immediate or day-to-day concerns was managed, consistent with CBT.

A strong and productive therapeutic relationship is required in schema therapy and SMA given the need to re-parent the unmet needs not only outside the sessions but also at the times they occur in sessions. Opportunities to model effective interactions should be taken by the therapist as they arise. For example, it was helpful to explain to Audrey the impact of her behaviours on the therapist in an appropriate empathic way that showed genuine care and flexibility and to set clear, effective working boundaries with her. The therapist also needed to validate and care for her needs as they moved between the different modes, from providing safety and support for the vulnerable child to empathetic confrontation when in some of the coping modes (Arntz and Jacob. 2013).

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