

REATTACH A NEW SCHEMA THERAPY FOR ADULTS AND CHILDREN?
PART I: ADULTS

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Abstract

Objective: Young's Schema Therapy (ST) has become widespread among practitioners that work with adults with maladaptive functioning such as participants with personality disorders or post-traumatic stress. This therapy focuses on identifying and adapting early maladaptive schemas that form the base of personality pathology. In a budget-constrained society both the costs and benefits of a new treatment form are important. 'ReAttach' is a short, and accessible new intervention for adults and children with maladaptive patterns based on the principles of attachment, social cognitive training and play.

To examine the effect of five sessions ReAttach on early maladaptive schemas in adults with a variety of psychological complaints. A second objective was to assess the transferability of the method and perform treatment integrity check for the professionals in training.

Method: Two cohorts of therapists (n=44 and n=22) were trained to perform ReAttach with two groups of participants (n=240 and n=82). The extent of maladaptive schemas was assessed with the Young Schema Questionnaire (YSQ3), before and after five ReAttach therapy sessions.

Results and Conclusions: the data reported here support the hypothesis that ReAttach may be an attractive experimental treatment for adults with maladaptive schemas. Although all therapists were newly trained, and therefore relatively inexperienced, a significant reduction of maladaptive schema scores on the YSQ3 was found

Key words: attachment, treatment, schema therapy

Declaration of interest: none

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I. Introduction

Psychological disorders may be viewed as maladaptive strategies of emotional regulation (Leahy 2012). Reduction of these emotion regulation problems may contribute to improvement of psychological health. Since emotion regulation problems have been related to borderline personality disorder, generalized anxiety, post-traumatic stress disorder, substance misuse, rumination, specific phobia and eating disorders (Barlow 2004, Craske 2008, Fairburn 2009, Fairburn 2003, Hayes 2011, Leahy 2011, Mennin 2004, Zweig 2011), a treatment that focusses on reduction of maladaptive emotional regulation strategies may benefit a broad range of adults with psychological disorders. Emotional disorders often share similar cognitive distortions and information-processing biases are not necessarily tied to a single disorder (Harvey 2004) so changing information-processing biases might be applied across a broad range of psychological disorders.

ReAttach is a multimodal intervention based on attachment, arousal regulation and the change of information-processing and cognitive structures. The intervention was developed in an attempt to create the same information processing conditions in the mind as during "play" (Bartholomeus 2013). The concept "ReAttach" was born and in attempting to deepen the understanding of the unexpectedly positive changes for adults with psychological complaints, more

professionals were trained and practical research was performed to measure the transferability of the method with the schema questionnaire YSQ3 from Young (Young 2003).

This study investigates the effectivity of the ReAttach intervention for adults with the hypothesis to find positive reliable changes in terms of reduction of maladaptive schema scores on the YSQ3 after 5 sessions ReAttach. Given the existing evidence of the role of information-processing bias in emotional disorders, ReAttach might be of value in reducing maladaptive behavior for a broad range of adults with psychological disorders.

This article will demonstrate with data coming from professionals during training, how therapists might profit from the inclusion of procedures as described in the multi-modal approach of ReAttach.

II. Methods

Two cohorts of therapists were trained to perform ReAttach with two group of participants. Each participant was offered five sessions of ReAttach, taking place within 3 months. Participants filled out the YSQ3 questionnaire prior to and after the five sessions of ReAttach, in order to assess the extent of their maladaptive patterns.

Study population

Cohort A: a group of 44 therapists was trained by the author to perform ReAttach with a group of participants with psychological disorders, of which each provided written informed consent (N=294). 14 participants were excluded: 13 due to lack of clinical scores on the questionnaire and 1 because of contra indications (table 1).

Table 1. Exclusion criteria for ReAttach

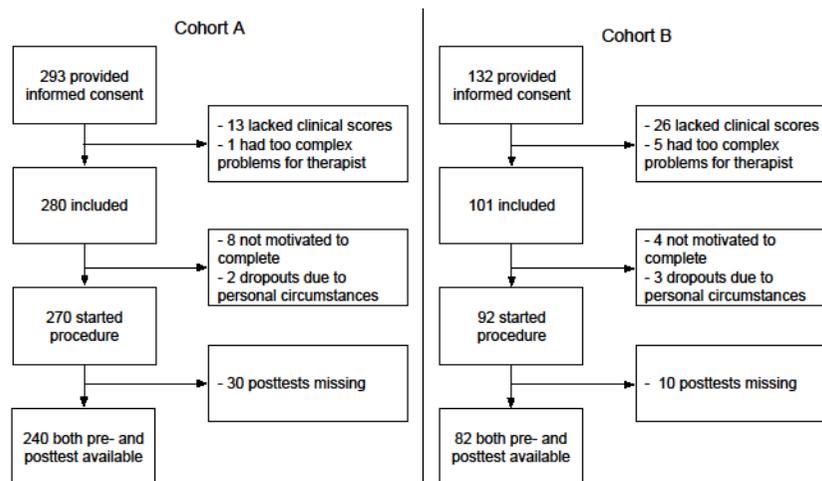
Exclusion Criteria for ReAttach	
YSQ3 pretest	No clinical schema scores
Contra Indications	Substance abuse
	Suicidal risk
	Psychotic features
	Crisis

270 completed the procedure of five sessions, 10 dropped out: 8 were not motivated to go on after the first session and 2 were not able to follow through due to personal circumstances. 30 post tests were not completed, and therefore 240 participants were used in order to assess the effects of ReAttach. The flow of participants is shown in figure 1 and their baseline characteristics can be found in table 1. Out of 270 participants 240 people filled in both pre- and post-measurements which means that 30 post tests were missing (0.11%).

Table 2. Characteristics of participants in cohort A and B. Data is presented as mean +/- standard deviation

	Cohort A (n = 240)	Cohort B (n = 82)
Age (years)	43.33 +/- 11.82	41.90 +/- 12.18
Gender (male)	28.3%	28.05%
YSQ3 total score (pretest)	616.61 +/- 154.49	598.45 +/- 143.03
Diagnose unknown or not diagnosed	161 (67.08%)	73 (89.02%)
Diagnosis	79 (32.9%)	9 (10.98%)
Personality Disorder	7 (2.92%)	1 (1.22%)
Depression	12 (5%)	
ADHD	5 (2.08%)	
Attachment Disorder	1 (0.42%)	
Post-traumatic Stress Disorder	12 (5%)	2 (2.44%)
Burn out	14 (5.8%)	4 (4.88%)
Anxiety Disorder	5 (2.08%)	1 (1.22%)
Brain Injury	3 (1.25%)	
Autism	4 (1.67%)	1 (1.22%)
Multiple diagnoses and problems	16 (6.7%)	

Figure 1. Participants flowchart



Cohort B: a group of 22 therapists was trained to perform ReAttach and started with a group of participants (N=132) that participated voluntarily in practical research with written informed consent. After exclusion of 31 participants due to underscores (N=26) and contra indications (N=5) there were 101 participants that were supposed to follow through. In fact there were 7 dropouts (4 not motivated after the first session and 3 due to personal circumstances). Out of 92 participants that followed the procedure of 5 sessions 82 completed pre- and post-measurements. There were 7 posttests missing (0.07%) and 3 participants (0.03%) wanted to extend the procedure and did not fill in the post measurement yet.

III. The ReAttach method

Conditions

Prior to performing a ReAttach session, both the therapist and the participant take place at a small table. The therapist explains the procedure, ensuring instructions towards the participant are understood.

ReAttach procedure

The therapist begins by regulating the arousal level of the participant. This is achieved through altering the therapist's attitude, voice, presence and attention and also through tactile input by tapping the participant's hands.

Simultaneously, the therapist stimulates multisensory channels, using both verbal prompts and visual exercises. ReAttach starts by letting the participant focus on negative information. The therapist's main objective is to restore healthy information processing. This is achieved by externally influencing the participants arousal, to an optimal high level (alert but not anxious) that is necessary to be able to conduct Multiple Sensory Integration Processing (MSIP). The therapist requires fully joint attention, without a sign of anxiety or fear (as during play). The therapist gives verbal prompts directing towards the concept of self, significant others, theory of mind and social concepts and relationships.

After this part of social cognitive training, the therapists guides the participant towards a very low arousal level (a near-sleep condition) by altering the tapping speed and adjusting his/her attitude and voice. This arousal level is optimal for adjusting concepts and training new skills.

The cues given to the participant during this part of a session differ between early and later sessions. During the first session, the therapist gives verbal prompts (while the participant is at a low arousal level) to collect positive information, such as all good memories. In later sessions, the therapists uses imaginary exposure techniques to learn new behavior and to experience new feelings. In addition, the therapist guides the participant to break up with inadequate coping styles (like dependence and passivity) by asking the participant to imagine himself conducting more adequate coping styles. By training opposite thinking patterns in the low arousal part cognitive bias modification is possible.

Statistics

Comparison of the means of the total scores on the YSQ3 before and after 5 therapy sessions was conducted with a paired samples T-test with a 95% confidence of the interval of the difference CIN (0.95).

IV. Results

Table 3 presents the results of the comparison of the total mean scores on the YSQ3 before and after treatment with ReAttach. All participants grouped (n=240) show a significant change (p<0.001) on the total scores of YSQ3. Differentiation on provided diagnoses

show significant changes in participants with anxiety disorder (p<0.05), burn-out (p<0.01), depression (p<0.001), personality disorder (p<0.05) and post-traumatic stress disorder (p<0.001). Participants with multiple diagnoses show significant changes (p<0.01) as well, albeit with a smaller effect size (0.52).

In **table 4** the results of the second cohort are presented and the means scores on the different schemas of the YSQ3 are compared. Significant changes (p<0.01) are obtained in all schemas. There is a significant change (p<0.01) on the total score with an effect size of 1.08.

V. Discussion

The purpose of this article is to inform researchers and clinicians about a possible new methodology for adults and children with maladaptive patterns. The objective of this research was to investigate the clinical potential of this method in terms of reduction of maladaptive strategies of emotional regulation.

This study demonstrates that the ReAttach method has a strong impact on the extent of maladaptive schemas of participants with a broad range of psychological problems.

Reviewing literature, ReAttach seems to contain elements of existing psychotherapies such as Cognitive Bias Modification (CBM) and Compassion Focused Therapy (CFT) that have proven to be important in clinical practice. According to CBM processing biases can be seen as a barrier to schema change. The most effective way to change automatic processes is training of the opposite process (Schneider 1997). ReAttach focusses on changing information-processing biases to automate new adaptive cognitive processes in order to (re)gain realistic concepts of the self, (significant) others and the world. In contrast with CBM, ReAttach does not focus on practicing to shift attention away from negative information. According to Gilbert's CFT individuals who are depressed may have deficits in their ability to invoke a compassionate, accepting, love-kindness towards themselves and beliefs about emotion are expected to impact problematic styles of coping (Gilbert 2005, 2009). The multimodal approach of ReAttach includes adjustment of negative beliefs into more realistic, compassionate and accepting attitudes and coping styles as CFT prescribes.

Given the existing evidence of the role of

Table 3. Cohort A results on the YSQ3 with differentiation between diagnoses

Total Scores YSQ3	N	M1	SD1	M2	SD2	M1-M2	t(df), p	ES
All participants	240	616.61	154.49	477.61	153.41	139.00	17.19(239), 0.000	0.90
Diagnose unknown / not diagnosed	161	585.01	138.78	455.59	141.70	129.52	14.52(160), 0.000	0.92
Asperger Syndrome	4	738.00	361.63	477.25	194.84	260.75	2.83(3), 0.066	ns
Attachment Disorder	1	600.00	-	670.00	-	-70.00	-	ns
Attention Deficit Hyperactivity Disorder	5	614.40	138.80	507.00	214.32	107.40	2.68(4), 0.055	ns
Anxiety Disorder	5	873.80	205.39	619.40	137.46	254.40	4.45(4), 0.011	1.45
Brain Injury	3	667.33	115.50	697.33	52.56	-30	-0.82(2), 0.497	ns
Burn-Out	14	615.36	136.98	501.64	142.03	113.71	3.29(13), 0.006	0.81
Depression	12	627.83	141.34	461.08	178.32	166.75	5(11), 0.000	1.04
Personality Disorder	7	744.86	141.99	533.00	162.29	211.86	3.10(6), 0.021	1.39
Post-Traumatic Stress Disorder	12	719.00	113.41	441.50	121.71	277.50	8.25(11), 0.000	2.36
Multiple Diagnoses and Problems	16	675.94	157.96	587.81	181.12	169.96	3.17(15), 0.006	0.52

Table 4. Cohort B results on the YSQ3 with differentiation between schemas

Schema (YSQ3)	M1	SD1	M2	SD2	M1-M2	t(df), p	ES
Emotional Deprivation	26.56	11.06	21.99	10.49	4.57	5.45(81), 0.0	0.42
Abandonment	42.32	15.61	30.93	11.90	11.39	7.56(81), 0.00	0.82
Mistrust / Abuse	38.82	13.88	30.20	10.00	8.62	6.76(81), 0.00	0.71
Social Isolation / Alienation	23.49	10.22	17.38	7.73	6.11	7.34(81), 0.00	0.67
Defectiveness / Shame	27.67	13.91	21.54	8.54	6.13	5.87(81), 0.00	0.53
Failure	22.29	11.14	16.34	8.69	5.95	6.15(81), 0.00	0.60
Dependence / Incompetence	29.85	13.77	22.38	8.94	7.48	6.56(81), 0.00	0.64
Vulnerability to Harm or Illness	24.54	10.84	18.50	6.44	6.04	6.40(81), 0.00	0.68
Enmeshment / Undeveloped self	22.05	12.41	16.80	7.66	5.24	5.26(81), 0.00	0.51
Subjugation	27.17	11.27	19.74	8.08	7.43	6.78(81), 0.00	0.76
Self-Sacrifice	63.52	15.39	47.79	15.92	15.73	9.25(81), 0.00	1.00
Emotional Inhibition	23.08	8.60	16.83	6.24	6.26	8.36(81), 0.00	0.83
Unrelenting Standards / hyper criticalness	50.83	14.94	37.52	14.72	13.30	8.88(81), 0.00	0.90
Entitlement / Grandiosity	26.40	7.96	21.67	6.58	4.73	5.68(81), 0.00	0.65
Insufficient Self-Control / Self Discipline	36.99	11.94	27.87	9.11	9.12	8.10(81), 0.00	0.86
Approval-seeking / Recognition-seeking	43.82	13.94	33.43	11.48	10.39	6.83(81), 0.00	0.81
Negativity / Pessimism	29.27	11.88	22.11	10.64	7.16	6.28(81), 0.00	0.63
Punitiveness	39.54	11.96	30.01	10.31	9.52	8.02(81), 0.00	0.85
Total Score	598.45	143.03	453.05	126.90	145.40	10.57(81), 0.00	1.08

information-processing bias in emotional disorders and looking at the promising results in these practical research studies, ReAttach appears to be of value in reducing maladaptive behavior for a broad range of adults with psychological disorders. The results of this study suggest that subgroups of participants with anxiety disorder, burn-out, depression, personality disorder and post-traumatic stress disorder benefit from ReAttach. Given the broad range of these subgroups it is plausible that persons with other psychopathological conditions might benefit as well. This would however require further investigation.

Looking at the effect sizes of the schemas from Cohort B it may appear that certain maladaptive schemas decrease more than other. The most important conclusion however seems to be that on every schema significant positive changes are obtained. Apparently the intervention influences maladaptive functioning as a whole. This is a very important clue in the development of a family schema intervention because ReAttach might be an effective tool for parent/child relationship improvement.

It is important to note that despite the requirement of therapeutic skills, this study clearly demonstrates that these two cohorts of therapists have been able to successfully learn the ReAttach method. Further practice of these newly trained skills will probably improve their results even more.

ReAttach changes negative attitudes against the self, significant others and the world very quickly. A great benefit of the method is the fact that the participant is in control of the therapy content and the therapist only offers the information processing conditions. The ReAttach "play" offers the participant the opportunity to be the leading actor and director of the therapy as well. For many participants, this position is a very helpful tool to learn how to take responsibility and direction of your own life.

These studies do not investigate the possible outcomes of newly trained adaptive cognitive processes and did not focus on the long-term outcome of possible

change of coping styles yet. Randomized controlled trials, including long-term investigation should be conducted to examine whether ReAttach can live up to these expectations.

Highlighting the clinical potential of modifying arousal regulation and information processing in adult participants with emotional problems might also contribute to other treatments and therefore be important to clinicians and researchers.

VI. Conclusion

In this study, we demonstrated that freshly-trained ReAttach therapists are able to greatly influence the schemas of a large and diverse group of adults with psychological complaints. In terms of cost effectiveness 'ReAttach' is a short and accessible intervention that might be an attractive alternative for long and more expensive psychological treatment.

Acknowledgment

Author thanks all people that have participated in this research. Specially she wants to thank prof. Michael Fitzgerald and Joey Roosen for their inspiration and support.

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