SA1: Appendix 1 : Details of training formats in schema therapy

| Cohort 1 | Cohort 2 |
|---|---|
| ***Number of training days*** | |
| 4 | 4 |
| ***Number of training hours*** | |
| 27 | 27 |
| ***A priori lecture material (studying required before training start)*** | |
| Three books on schema therapy* | Three books on schema therapy* |
| ***Lecture material during training*** | |
| Handouts A (194 pp) | Handouts A (194 pp) plus Handouts B (11 pp) |
| ***Number of trainers*** | |
| 6 (one head and 5 help trainers) | 1 |
| ***Number of trainees*** | |
| 56 | 20 |
| ***Trainer to trainee ratio*** | |
| 1 to 9.3 | 1 to 20 |
| ***Theory-practice ratio*** | |
| 75% theory vs 25% practice | 25% theory vs 75% practice |
| ***Training structure*** | |
| Lectures in theoretical underpinnings (20 hrs)<br>Video demonstrations (4 hrs)<br>Role-play exercises in couples or triplets (3 hrs) | Lectures in theoretical underpinnings (4 hrs)<br>Video demonstrations (1 hrs)<br>Plenary role-play demonstrations (2 hrs)<br>Role-play exercises in couples or triplets with plenary discussion afterwards (20 hrs) |
| ***Role-play exercises*** | |
| 1. Make a schema mode model of one's patient<br>2. Empty chair technique to fight punitive/demanding parent mode<br>3. Imagery rescripting of childhood memory (vulnerable child mode) | 1. Imagery of own (counter)transference experience & associated own childhood memory<br>2. Make a schema mode model of one's patient<br>3. Pro's & con's of coping modes<br>4. Imagery rescripting of childhood memory (vulnerable child mode)<br>5. Empty chair technique to fight punitive/demanding parent mode<br>6. Limit setting (generic)<br>7. Anger venting (angry child mode)<br>8. Empathic confrontation (impulsive/undisciplined child mode)<br>9. Advanced cognitive techniques (healthy adult mode)<br>10. Flashcards (generic)<br>11. Behavioral change (healthy adult mode) |
| ***Individual feedback on role-play exercises*** | |
| Limited | Extensive, with plenary discussion afterwards |

Note. *These books were (Dutch translations were available):
Young, J.E. & Klosko, J.S. (1994). Reinventing your life. New York: Plume.
Young, J.E., Klosko, J.S. & Weishaar, M.E. (2003). Schema Therapy: A practitioner's guide.
van Genderen, H. & Arntz, A. (2005). Schemagerichte cognitieve therapie bij borderline persoonlijkheidsstoornis. (Schema Therapy for Borderline Personality Disorder) Amsterdam: Uitgeverij Nieuwezijds.



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SA2: Appendix 2 : Detailed procedure of statistical analyses

Results were analyzed according to the intention-to-treat principle with SPSS-19 logistic and linear mixed regression, with center as random effect (random intercept, random slope if applicable). For repeated measures unstructured covariance was used. ST and COP were coded as (1,0)-dummies with TAU as reference, and for the ST-COP contrast ST was coded 1, and COP 0. TAU-participants of sites with ST-therapists trained in one wave got identical cohort-codes. For sites with mixed ST-therapist waves, second ST-cohort therapists were in minority, and TAU-cases matching in gender, age and primary diagnosis to second cohort ST-cases were coded as second cohort[18]. Cohort was centered (-.5 for first cohort, 0 for clarification oriented psychotherapy, .5 for second cohort) and used as covariate (including its interactions with time, condition, and time*condition), so that other effects were controlled for cohort at zero cohort-effect. Also baseline severity was used as covariate in analyses of diagnostic outcomes unless indicated; not in repeated measures analyses due to high correlations with baseline levels on secondary measures. Baseline severity-index was a centered composite measure based on standardized baseline values of # axis-I disorders, # axis-II disorders, ADP-IV trait-and distress-scores, SCL-90, GAF, SOFAS, and disability (internal consistency .77). Effects were estimated at the center of the severity composite (severity = 0). For the primary outcome a series of sensitivity analyses was done, testing effects of not-controlling for baseline severity, primary PD, time and type of assessment, whether the indicated treatment did effectively start, recovery definition, medication use at treatment start and during the 3-year study period. Dropout was analyzed with Cox regression survival analysis controlling for severity and cohort, as well as with mixed logistic regression using the same model as in the primary outcome analysis. Estimation failed in mixed analyses of depressive and anxiety disorder presence at 3 year. To account for missing data, multiple imputation followed by logistic regression was used, a method based on the same assumptions about missingness as mixed regression[1]. For diagnostic outcomes we



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report effects of all condition comparisons, schema therapy*cohort, and severity and sensitivity-covariates if applicable. For repeated measures we report effects of time, all condition comparisons of time effects, and (schema therapy – treatment-as-usual)*cohort*time as relevant for the research questions. In deviation to the original analysis plan[2], we reported ST-COP contrasts even when the COP-TAU contrast was N.S., as requested by the journal's editor.

References


1. Schafer JL, Graham JW. Missing data: our view of the state of the art. *Psychol Methods.* 2002; 7:147-177.
2. Bamelis LLM, Evers S, Arntz A. Design of a multicentered randomized controlled trial on the clinical and cost effectiveness of schema therapy for personality disorders. *BMC Public Health.* 2012; 12:75.




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