JAN KOSSACK

- born in Freiburg i. Brg. / Germany
- Education & Training:
- University of Trier (Psychology) 1992-1998
- University of Zurich (forensic psychotherapy) 2009-2013
- Schema Therapy (NYC & New Jersey Institute for ST, Jeffrey Young & Wendy Behary)
- Work experience:
- Therapist for aggressive adolescents & adults, teens & adults, who were perpetrators of sexual abuse,
- Family, individual and couples therapist in private practice in Luxembourg, Barcelona - www.upgradeyourlife.lu
- ST Trainings in Switzerland, France, Luxembourg, Spain, India and Morocco

DOWNLOAD THE SLIDES AT:

WWW.JANKOSSACK.COM

AND THEN GO TO INDIA ST TRAINING

DATES OF THE TRAINING

MODULE 1:
17 & 18 JANUARY 2025
BY JAN KOSSACK

MODULE 2:
03 & 04 MARCH 2025
BY JAN KOSSACK (ONLINE)

MODULE 3:
07 & 08 MAY 2025
BY DR. ANOUSHA HADINIA (ONLINE)

MODULE 4:
09 & 10 JULY 2025
BY DR. ANOUSHA HADINIA (ONLINE)

IN TOTAL 8 DAYS OF 6 HOURS EACH
TOTAL HOURS OF TRAINING: 48H

WHAT IS SCHEMA THERAPY?

PRESENTATION OF PARTICIPANTS

- ...experiences with ST
- ...why do you want to learn ST
- ...profession
- ...field of activity

THE PROGRAM

AGENDA

- Schema Therapy (ST) theory and case conceptualization
- The therapeutic relationship
- The techniques of ST (cognitive, experiential, and behavioral)
- ST for different personality disorders

MODULE 1

1.1. Schema theory / concept

- schemas, coping styles and modes: defined and differentiated

- diagnosis of schemas and modes: exploration, imaging, questionnaires

- the needs / rights of the child

1.2. planning the treatment & conceptualization of a case

- clarifying goals in the context of patterns and modes

- case conceptualization in terms of patterns and modes

concept...
and
the general
context

1.1. SCHEMA THEORY

OVERALL CONTEXT:

- developed by Jeffrey Young
- to more effectively treat patients with personality disorders who do not respond to or relapse from traditional cognitive therapy
- initially Young's model focused on individual therapy
- later ST was also practiced with couples, groups, children/adolescents and families

OVERALL CONTEXT (2):

- developed on the basis of CBT
- ST is an integrative approach: Young integrated CBT with Gestalt Therapy, with ideas of attachment,...
- in the last years some ideas from positive psychology or Acceptance & Commitment Therapy are integrated as well
- ST is strongly biographically oriented

OVERALL CONTEXT (3):

- ST is focused on developing experiential interventions to address emotional learning gaps and
- provide corrective emotional experiences related to attachment and emotional regulation
- ST uses a limited reparenting therapeutic style
- for ST the integration of experiential, cognitive, and behavioral interventions is important to achieve treatment goals.

Farrel, Shaw and Belhourania 2021

EMPIRICAL VALIDATION...

- The effectiveness of ST in patients with Borderline personality disorder has been empirically validated in several large-scale studies of individual ST
- (Giesen-Bloo et al. 2006; Nadort et al. 2009; Farrel, Shaw, and Webber 2009; Reiss, Lieb, Arntz, Shaw, and Farrell 2014; Dickhaut and Arntz 2014; Bamelis, Evers, Spinhoven, and Arntz 2014; Bernstein et al. 2012;...)
- Farrel, Shaw, and Belhourania 2021

Farrel, Shaw et Belhourania 2021

CORE CHILDHOOD NEEDS

- core physical needs
- core emotional needs

CORE PHYSICAL NEEDS

- drink
- eat
- sleep
- breathing

THE 5 CORE EMOTIONAL NEEDS

- Security related to **attachment** to others (which includes: stability, safety, caring education and acceptance)
- Autonomy, competence and a sense of identity
- Freedom to express needs and emotions and validation of these
- Spontaneity and play
- Realistic limits to promote self-control

ATTACHMENT

Safety, stability, care, acceptance, care and protection

"I know someone is there for me; a stable person who loves me, understands me, supports me and protects me".

"I feel useful because my caregivers show me that I am useful to them".

AUTONOMY

I know my skills.

I can face challenges and new situations independently.

I have my own will, which is recognized by others.

My caregivers are there for me, but I have an inner world and body of my own, separate from them.

EXPRESSING NEEDS AND EMOTIONS

I am allowed to show my feelings and my feelings are accepted.

My caregivers care about and respect my feelings and needs.

BEING PLAYFUL AND SPONTANEOUS

I can perceive my own feelings and my ideas are respected.

I have the right to be cheerful and to give free rein to my spontaneous impulses.

REALISTIC LIMITS

I am aware of other people and have learned to respect their needs, ideas and emotions.

I know and respect social rules.

I am able to control my emotions and behaviour.

THE FIRST CUT IST THE DEEPEST....

STILL FACE - ED TRONICK

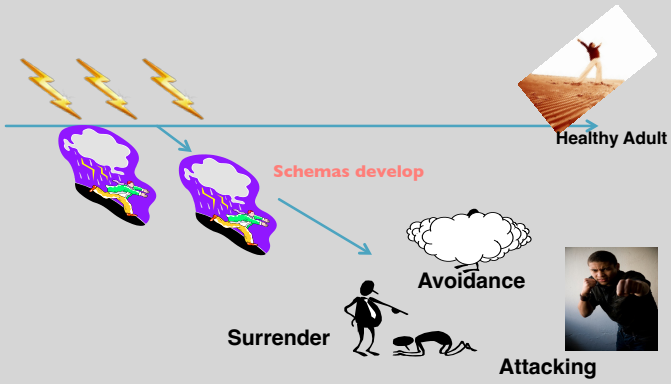
HTTPS://YOUTU.BE/APZXGEBZHTO

CENTRAL IDEAS OF SCHEMA THERAPY

- The primary origins of most personality disorders are core emotional needs, which were not met during childhood or adolescence - especially those, which are linked with parenting/attachment problems.

- If core emotional needs have not been met during childhood, children very often develop problems establishing strong bonds with other people later in life.
- Most of our clients with a severe personality disorder, such as BPD or NPD or APD, have very strong difficulties with relationships as adults.
- If the core emotional needs have not been met, maladaptive early schemas and modes develop.

SCHEMAS & COPING



WE ALL HAVE SCHEMAS!

WHAT ARE SCHEMAS?

- Filter present cues based on past
- Anticipate future based on past

DEFINITION OF EARLY MALADAPTIVE SCHEMAS:

- an important pattern or theme
- consisting of memories, emotions, cognitions and body sensations
- about oneself and one's relationships with others
- formed during childhood or adolescence
- enriched throughout the individual's life and
- dysfunctional in a significant way.

SCHEMAS ARE LIKE

FILTERS OR GLASSES

THE DOORBELL METAPHOR

SCHEMA DOMAINS:

- Domain I: separation and rejection
- Domain II: lack of autonomy and performance
- Domain III: lack of boundaries
- Domain IV: Orientation towards others
- Domain V: Over-vigilance and inhibition

DOMAIN I: SEPARATION AND REJECTION

- Abandonment / Instability schema
- Mistrust / Abuse Schema
- Emotional Deprivation Schema
- Defectiveness / Shame Schema
- Social Isolation Schema

unmet need:

secure attachment

DOMAIN II: LACK OF AUTONOMY AND PERFORMANCE

- Schema of Dependence / Incompetence
- Vulnerability Schema
- Enmeshment Schema
- Failure Schema

Unmet need:

autonomy

DOMAIN III: LACK OF BOUNDARIES

- Entitlement Schema
- Schema of insufficient self-control

Unmet need:

Realistic limits

DOMAIN IV: ORIENTATION TOWARDS OTHERS

- subjugation schema
- self-sacrifice schema
- Approval seeking schema

Unmet need:

express my needs and emotions

DOMAIN V: OVER-VIGILANCE AND INHIBITION

- Negativity Schema
- Emotional Inhibition Schema
- Unrelenting Standards Schema
- Punitiveness Schema

Unmet need:

Being playful & spontaneous

VIDEO: STARTING THERAPY WITH LUCY

WHAT WERE THE THERAPIST'S GOALS?

WHAT INFORMATION DID SHE LOOK FOR?

THE SCHEMAS

Examples videos

ABANDONMENT / INSTABILITY

People with this schema are convinced that important relationships will never last and therefore, they are constantly faced with the fear of being abandoned or disappointed by others. They feel lonely and abandoned, with no one to reliably provide protection, emotional support, connection or warmth.
People with this profile report childhood experiences of abandonment, such as abandonment by a parent, untimely death of important caregivers, or frequent loneliness.

FILM ABANDONMENT SCHEMA

MISTRUST & ABUSE

People with this schema expect to be used, abused, mistreated, deceived or humiliated by others. As a result, they find it very difficult to establish trusting relationships with others. Affected individuals are constantly on guard against others because they fear being deliberately hurt or abused by them. The biographical context is usually made up of experiences of abuse of various kinds (e.g., they have been lied to, cheated on, hurt, mistreated or manipulated).

EMOTIONAL DEPRIVATION

People with this schema expect that their emotional needs will not be met at all or will not be met adequately by others. These needs are support, attention, affection, understanding, compassion or warmth, guidance, assistance and protection. In their lives, they have rarely experienced the feeling that someone cares for them in a caring and loving way or that they are safe, cared for and loved. In most cases, there was little physical affection in childhood, and love was conditional. This schema leads to intense feelings of loneliness and misunderstanding.

DEFECTIVENESS / SHAME

This schema describes the feeling of being inadequate, bad, inferior or undesirable. Sufferers feel that they will never be worthy of love, attention or respect from others, no matter how hard they try. They have a deep sense of shame about who they are. In childhood, the need for recognition, praise and acceptance was not sufficiently met. Parents were often overly critical, embarrassing them as children and devaluing them when they expressed needs or feelings.

FILM DEFECTIVENESS / SHAME

SOCIAL ISOLATION

This schema describes the feeling of being cut off from the rest of the world, of not belonging or of being profoundly "different" from others. Affected individuals feel that they do not belong to groups, even though they may be discrete and integrated from the outside. Affected individuals report experiences of isolation in childhood.

DEPENDENCY SCHEMA

People with this schema often feel helpless and unable to tackle things or accomplish tasks without the support of others. They have difficulty making independent decisions. They often come from (clingy) family relationships in which they have been overprotected. Confidence in their own skills may not have been sufficiently developed due to diminished responsibility, lack of praise and lack of guidance for independence.

VULNERABILITY

This schema is characterized by a pronounced fear of disasters, illnesses or other problems that may strike people unexpectedly. Affected individuals often report having had very anxious caregivers as children; in some cases, severe misfortunes or illnesses actually occurred in their immediate environment.

ENMESHMENT SCHEMA

Excessive emotional involvement and closeness to one or more significant persons (often parents), to the detriment of full individuation or normal social development. It often involves the belief that at least one of the people involved cannot survive or be happy without the constant support of the other. May also include a sense of being merged with others or an inadequate individual identity. Often expressed as a sense of emptiness, lack of direction or, in extreme cases, questioning one's existence.

FAILURE SCHEMA

This schema includes the belief that one will never succeed, that one is less talented or less intelligent than almost everyone else. People with this pattern have often been subjected to highly critical comments, for example at school or at home, usually accompanied by a radical devaluation of their person.

FILM LITTLE ISBALLE (JEFF & WENDY)

ENTITLEMENT SCHEMA

This schema describes the belief of being special and feeling superior to others. Affected individuals have the attitude that they have special rights and do not have to worry about the needs of others, rules or conventions. They hate being restricted or held back. Often they were taught as children that they or their family were special and spoiled, at least materially. Often, this schema also arises from learning by modeling, when parents themselves conform to this schema.

INSUFFICIENT SELF-CONTROL SCHEMA

People with this schema have difficulty controlling themselves and tolerating frustration when it comes to achieving their goals. They often give up on boring activities and have little patience for tasks that require discipline and perseverance.

SELF-SACRIFICE SCHEMA

People with this schema are constantly focused on meeting the needs of others and supporting others. Attention to one's own needs often leads to feelings of guilt. Unlike the submissive schema, it is less about adapting and more about quickly recognizing each need and meeting it yourself if possible.

SUBJUGATION SCHEMA

People with this schema, fearing negative consequences in their relationships, always give others the upper hand and conform to the wishes and ideas of others, even if they can only guess at them. They think that their wishes, opinions and emotions are not appreciated by others.

APPROVAL SEEKING SCHEMA

People with this schema seek recognition, appreciation and approval in an exaggerated way. They place a high value on beauty, appearance, high social status, etc. in order to gain the praise and approval of others. This is often at the expense of their own needs and the development of a strong and authentic sense of self-worth. Self-esteem is primarily dependent on the reactions of others.

NEGATIVITY SCHEMA

This schema encourages people to see everything that is bad, negative and problematic. The positive aspects are minimized or ignored. Affected people are constantly afraid of making serious mistakes. As a result, they have difficulty making decisions, are constantly worried, always on the alert. They are very busy with previous negative experiences.

EMOTIONAL INHIBITION

People with this schema are afraid or uncomfortable showing their emotions or being spontaneous. They are afraid of displeasing others, losing impulse control and feeling ashamed. Their own needs and feelings, such as anger or joy, are suppressed, conversations about their own vulnerability or problems are avoided or even considered ridiculous and devalued.

UNRELENTING STANDARDS SCHEMA

People with this schema feel under constant pressure to get things done, achieve goals and be the best at everything. They always feel that they are never good enough and that they always have to try harder. Affected people are very critical of themselves and others. Perfectionism, rigid rules and a constant concern for time and efficiency follow. This is at the expense of interpersonal contacts, pleasure, leisure and relaxation.

PUNITIVENESS SCHEMA

This schema describes the belief that people should be severely punished when they make mistakes. People who suffer from this are unforgiving and impatient with themselves and others.

EXAMPLE:
MARIE
21 YEARS OLD
BORDERLINE PERSONALITY DISORDER

Alcoholic mother, absent and authoritarian father, violent stepfather who also often beat Marie.

Boarding school from 14 years old,
foster home from 15 years old,
arrived in a home for young adults at 17.

3 suicide attempts at age 19 due to arguments and relationship breakdowns.

She has been living with her boyfriend for some time.

For several months she has been arguing frequently with her boyfriend, she is unemployed and depressed.

It's Monday night. Paul (her boyfriend) usually gets home from work around 6pm.
She is waiting for him and is looking forward to seeing him.
She has cooked something and is now watching TV.
At 6:15 p.m., Paul is not there yet.

She feels anxious.

Her heart is racing, she starts to shake and has a lump in her throat.

She imagines that Paul is with another woman.

She is more and more sure that he will leave her.

When Paul comes home at 6:30 p.m., Mary can't control herself.

She screams, makes a terrible scene and throws Paul's things on the floor.

WHAT SCHEMAS WERE ACTIVATED IN MARY'S MIND BETWEEN 18:00 AND 18:30?

UpgradeYourLife
Counseling & Psychotherapy by Jan Kossack

SCHEMA FORM FOR MARIE:

	Mother	Father	As a child	Family rules
Biography				
Unmet core emotional needs				
Schemata				
Behavior / modes				

www.upgradeyourlife.lu

Breakout rooms:
Two-person group to complete „Schema form for Marie“ sheet

20min

SCHEMA THERAPY GENERAL APPROACH:

2 PHASES IN SCHEMA THERAPY

- Diagnostic & Psychoeducation
- Change

INITIATING SCHEMA THERAPY

- identify core problems and symptoms
- what core needs are not being adequately met?
- is the patient suitable for ST treatment?

IDENTIFY „LIFE PATTERNS“

- conduct a life history interview
- look for patterns related to current problems, such as partner choice ("schema chemistry"), job or career problems, relationship conflicts

EDUCATE PATIENTS ABOUT THE APPROACH

- Explain the concepts of needs, schemas and coping styles.
- Ask to read introductory chapters to "Reinventing My Life" (Jeffrey Young)

DIAGNOSTIC

- Interview
- Genogramm
- River of Life
- Questionnaires
- Diagnostic imagery

IMAGERY

IMAGERY:

DIAGNOSTIC IMAGERY

IMAGERY RESCRIPTING

IMAGERY

PRINCIPES

- attunement
- therapist helps to fulfill core needs in the image
- provide a powerful emotionally corrective experience

DIAGNOSTIC IMAGERY - REMCO - STEP BY STEP

DIAGNOSTIC IMAGERY PROCESS - 1

- start with the safe place
- let the patient describe, what he/she sees, smells, listens to, ...with all senses...
- let the patient enjoy this safe and peaceful place
- ask the patient to let this image disappear with the knowledge that he can come back to this place any time he wants...
- let the patient imagine a scene from the present life, where he/she felt sad, angry,... during the last weeks...
- let the patient revisit this current memory and ask him to tell what is happening in this scene - help the patient to revisit all the details of the scene, as he would like to be there again...

DIAGNOSTIC IMAGERY : PROCESS - 2

- let them describe exactly the kind of situation they are in;
- ask, what exactly is happening in the picture;
- ask: - about the feelings, - what was said, - what were the thoughts, - where the patient can feel his feelings in the body...
- make sure that the patient's feelings are clearly activated again
- use the AFFECT - BRIDGE...

DIAGNOSTIC IMAGERY: PROCESS - 3

the AFFECT BRIDGE...

- tell the patient to feel his feelings (physical and emotional) now, he must stay with these feelings
- but let the image of the present situation disappear and let it drift into the past, and let possible images from the past arise in which he felt the same way.

DIAGNSOTIC IMAGERIE : PROCESS - 4

- ask the patient if images from the past (childhood or adolescence), possibly with the mother or father, have appeared
- the patient MUST NOT SEEK, but simply let himself drift and observe if images appear
- this is a rather passive process
- if an image has appeared, then explore the situation

DIAGNOSTIC IMAGERY: PROCESS - 5

- encourage the patient to imagine that he or she is in that past situation again;
- explore the exact details of the situation (the place/room, who is there, what time is it, who is saying what, how does the child feel,...)
- ask the child what the child needs and from whom?
- if it is diagnostic imaging:
- when you have a clear understanding of what the child felt and needed in the image,
- ask the patient to let the image disappear again and return to the safe place;

DIAGNOSTIC IMAGERY : PROCESS - 6

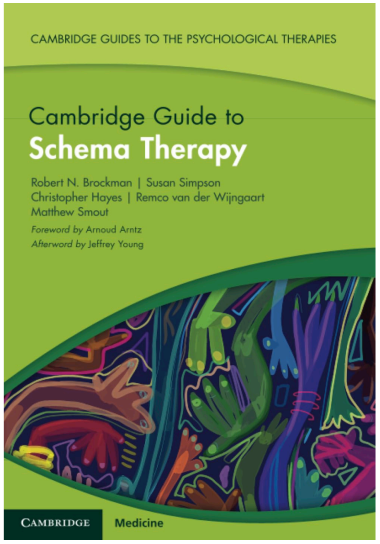
- briefly restate the various aspects of the safe place and allow the patient to enjoy it for a few moments
- then reorient the client to the here and now
- Debrief with the client about the imagery and core unmet childhood needs associated with the current situation, and the schemas that may have resulted.

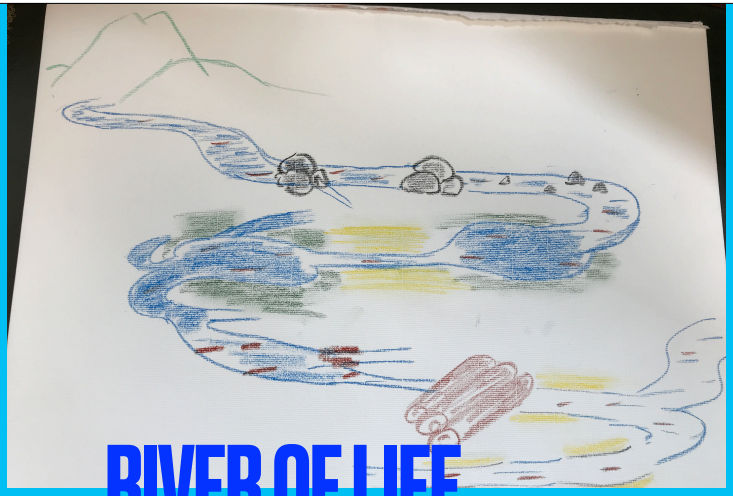
Exercise (60min):
Breakout-rooms in pairs
try to do the diagnostic imaging and debriefing with one patient following the process described above

each person as a therapist ONCE

THE PERSON, WHO PLAYS THE PATIENT - DO NOT MAKE IT TOO HARD AND TAKE A PATIENT, WHO YOU KNOW WELL OR YOURSELF

Very recommendable book from 2023:





RIVER OF LIFE

a possibility to get ideas on schemas of the patient

RIVER OF LIFE - 1

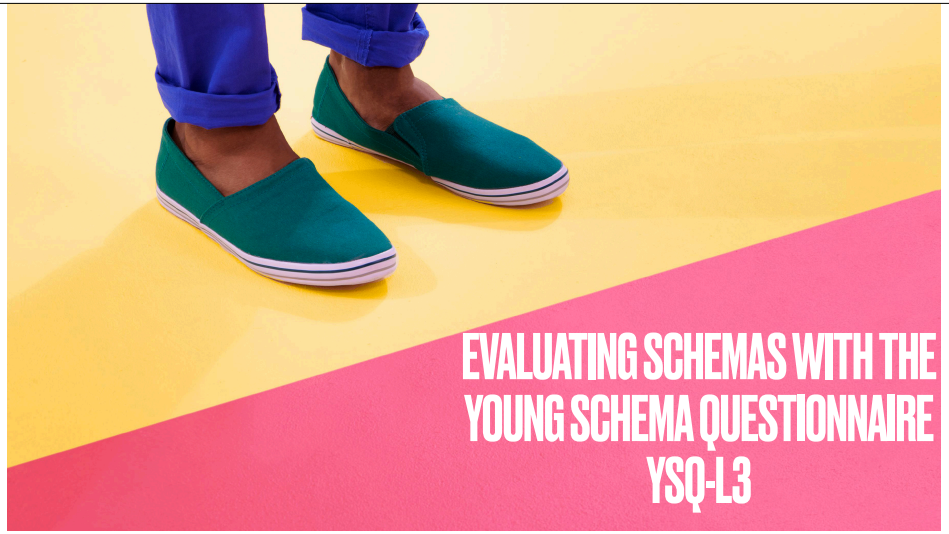
- I want to get to know you better today.
- I want to ask you to draw a picture of your life. But imagine that your life is a river.
- A river usually starts with a small spring. At first it's a small stream, then it gets bigger and bigger.
- It's like us.
- I like the comparison to a river, because a river doesn't always flow in a straight line, but has many bends and changes in direction. This is also often the case in our lives.
- In a river, there are sometimes obstacles (stones, wood,...), as in life. Sometimes there are waterfalls, which are a big cut. We also know this in our life (moving, big change,...). Sometimes a new tributary joins and brings new clean water. It can be an important person who has entered our life at some point.

RIVER OF LIFE- 2

- However, in some rivers there are also whirlpools, where you can be pulled down. You may have also had this feeling in your life, the feeling of sinking.
- In some places, the river is very calm, peaceful and wide. It feels like a vacation. But the river can also be narrow, rough, dangerous with rapids. That's what life can feel like, too.
- On some rivers, factories dump their wastewater into the river, poisoning it. This feeling is perhaps similar to the feeling we get when someone has done us a lot of harm.
- I would now like to invite you to paint your own river of life for the next 15 minutes. During this time, of course you will not be able to paint everything that was important in the river, but just see what you can think of the good or sad / difficult, formative moments in your life.
- It is your life - so it is also your river - so you cannot do anything wrong.

QUESTIONNAIRES

DE JEFFREY YOUNG



EVALUATING SCHEMAS WITH THE YOUNG SCHEMA QUESTIONNAIRE YSQ-L3

- 232 questions
- scale from 1 (not at all) to 6 (completely me)
- 18 schemas are integrated
- give the questionnaire to the patient, ask him/her to fill it in and make the evaluation
- discuss the results with the patient
- link the high scoring schemas to the patient's current life problems
- determine which schemas are most central to the client's core problems

YSQ – L3

Jeffrey Young, Ph.D

Name _____ Date_____

INSTRUCTIONS:

Listed below are statements that someone might use to describe him or herself. Please read each statement and decide how well it describes you. When you are not sure, base your answer on what you emotionally **feel**, not on what you **think** to be true.

If you desire, reword the statement so that it would be *even more accurate* in describing you (but do not change the basic meaning of the question).

Then choose the **highest rating from 1 to 6** that describes you (including your revisions), and write the number on the line before each statement.

RATING SCALE:

1 = Completely untrue of me
2 = Mostly untrue of me
3 = Slightly more true than untrue
4 = Moderately true of me
5 = Mostly true of me
6 = Describes me perfectly

EXAMPLE:

A. __4__ I worry that people *I care about* **will not like me.**

1. _____ People have not been there to meet my emotional needs.
2. _____ I haven't gotten enough love and attention.
3. _____ For the most part, I haven't had someone to depend on for advice and emotional support.
4. _____ Most of the time, I haven't had someone to nurture me, share him/herself with me, or care deeply about everything that happens to me.
5. _____ For much of my life, I haven't had someone who wanted to get close to me and spend a lot of time with me.
6. _____ In general, people have not been there to give me warmth, holding, and affection.
7. _____ For much of my life, I haven't felt that I am special to someone.
8. _____ For the most part, I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings.
9. _____ I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do.

ovf

10. _____ I worry that the people I love will die soon, even though there is little medical reason to support my concern.

M137

Scoring Sheet for

Young Schema Questionnaire

L3

Schema Name (Shortened)	YSQ Code	YSQ Item Numbers (Total Items)	Number of Statements You Rated: 4	5	6	Your Total for this Schema (Max. Possible)	Is This One of Your Schemas?
SAMPLE	xx	300-309 (10)	1	2	2	26 (60)	High
Emotional Deprivation	ed	1-9 (9)				(54)	
Abandonment	ab	10-26 (17)				(102)	
Mistrust/Abuse	ma	27-43 (17)				(102)	
Social Isolation	si	44-59 (16)				(96)	

M138

Interpretation Grid for

Young Schema Questionnaire – L3

Schema Name (Shortened)	Your Score On This Schema	Graph Your Score On This Schema: Low	Medium	High	Very High
SAMPLE	26	0-8	9-18	√ 19-30	31-60
Emotional Deprivation		0 - 8	9 - 18	19 - 30	31 - 54
Abandonment		0 – 12	13 – 25	26 – 39	40 - 102
Mistrust/Abuse		0 – 12	13 – 25	26 – 39	40 - 102
Social Isolation		0 – 8	9 – 18	19 – 30	31 - 96

OTHER QUESTIONNAIRES

- Young Parents questionnaire (YPI)
- Schema Mode Inventory (SMI)

SMI (Version 1.1)

INSTRUCTION: Listed below are statements that people might use to describe themselves. Please rate each item based on **how often** you believe or feel each statement **in general** using the frequency scale.

FREQUENCY: In general

1= Never or Almost Never
2= Rarely
3= Occasionally
4= Frequently
5= Most of the time
6= All of the time

Frequency	In general...
	1. I demand respect by not letting other people push me around.
	2. I feel loved and accepted.
	3. I deny myself pleasure because I don't deserve it.
	4. I feel fundamentally inadequate, flawed, or defective.
	5. I have impulses to punish myself by hurting myself (e.g., cutting myself).
	6. I feel lost.
	7. I'm hard on myself.
	8. I try very hard to please other people in order to avoid conflict, confrontation, or rejection.
	9. I can't forgive myself.
	10. I do things to make myself the center of attention.
	11. I get irritated when people don't do what I ask them to do.
	12. I have trouble controlling my impulses.
	13. If I can't reach a goal, I become easily frustrated and give up.
	14. I have rage outbursts.
	15. I act impulsively or express emotions that get me into trouble or hurt other people.

- FIGHT
- FLIGHT
- SURRENDER

3 COPING STYLES

COPINGS STYLES

- surrender/capitulation: compliance
- avoidance: substance abuse, detachment, social isolation, avoidance, stimulation, workaholism,...
- overcompensation: aggression, hostility, excessive autonomy, manipulation, demands, perfectionism, excessive control, ...

KEY TO THERAPY

WORKING WITH MODES

THE MODES

DEFINITION

- A mode is a predominant state we are in at any given time.
- Modes include the schemas, coping behaviors and healthy responses, that we are experiencing at the moment.
- Patients move from one mode to another in response to external and internal stimuli.

THE MODES…

- Modes are parts of the self, which have not been fully integrated.
- We fall into maladaptive modes when our core needs are not met enough and our schemas are triggered.

DIFFERENT KIND OF MODES:

- Child modes
- dysfunctional parent modes
- coping modes:

a) avoiding modes

b) over-compensation modes

c) surrender mode

- healthy modes

CHILD MODES

- Vulnerable Child
- Angry child
- Undisciplined child
- impulsive child

VULNERABLE CHILD

1. Vulnerable Child (Abandoned, Abused, or Humiliated Child) -- feels vulnerable, overwhelmed with painful feelings, such as anxiety, depression, grief, or shame/humiliation.

The manifestations of the Vulnerable Child can be more obvious or subtle. For example, sadness or grief can be manifested openly through crying or speaking openly about feelings of inner pain. Or more subtly, through lowered voice, downcast eyes, quiet, introspective demeanor, sad facial expression, sighing, slumped shoulders, and so forth. Feelings of anxiety can be manifest openly in feelings of panic, shock, startle, rapid breathing, or more subtly in stuttering, rapid speech, losing track of the thread of the conversation. The content of the conversation typically matches these expressions of vulnerability, for example, talking about recent or past experiences of loss, violence, hurt, etc. On the other hand, sometimes patients may stay silent or avoid talking about painful topics, but still show the non-verbal manifestations of the vulnerable child (e.g., facial expressions of sadness or anxiety). Because the vulnerable child involves intense feelings of inner pain, it often leads to attempts to escape from or avoid painful feelings. Thus, patients may rapidly switch from vulnerable child mode to other modes, which may show itself in suddenly falling silent, becoming angry or arrogant, or changing the topic of conversation.

LONELY CHILD

Lonely Child – feels lonely and empty, as if no one can understand him, sooth or comfort him, or make contact with him.

The Lonely Child feels sad, lonely, empty, and disconnected from other people. He feels that he will always be alone in life, that others will neglect him, or ignore him. He feels that he has to take care of things on his own, because no one will want to meet his needs. He feels that no matter what he does, no one will understand him. He may feel that this is his fate in life. That he is destined or determined to bear the burden of his loneliness. He may feel devoid of love, or even devoid of a sense of personal identity, as if his existence has no meaning.

Patients often describe feelings of being alone, even in situations when others are present. They may describe feelings of connection to nature, mankind, doctrines, abstractions or belief systems, or the spiritual, but not to specific people.

The Lonely Child obviously has some similarities to the Vulnerable Child, but is more of an interior experience, so it is less likely to involve strong overt expression of feelings. Usually, the Lonely Child remains hidden from view, but it may become evident when the patient talks about feeling isolated, not understood, ignored, or feeling unimportant or invisible. Sometimes, life events may trigger the emergence of the Lonely Child, for example, the death of a family member or friend, or long periods of isolation. In these cases, the pain of the Lonely Child may suddenly become evident.

ANGRY CHILD

Angry Child – feels and expresses uncontrolled anger or rage in response to perceived or real mistreatment, abandonment, humiliation, or frustration; often feels a sense of being treated unjustly; acts like a child throwing a temper tantrum.

Angry child is evident in uncontrolled, or poorly controlled, expressions of anger. More extreme manifestations include screaming, shouting, swearing, throwing things, banging on things, breaking things. More subtle manifestations include hard breathing, loud voice. The content of the angry child mode almost always involves a sense of injustice or unfairness that has been perpetrated on the person. This feeling of injustice can be justified, but often involves some distortions or a disproportionate reaction to the provoking incident. At times, the person may be very quickly triggered to anger, or the trigger for the anger may not be obvious.

In contrast to the Angry Protector, the Angry Child mode involves uncontrolled or poorly controlled anger, as opposed more controlled expressions of hostility or oppositionality. The Angry Child mode serves the purpose of ventilating anger about a perceived injustice, whereas the Angry Protector serves to make distance from

others. In contrast to the Bully and Attack mode, the Angry Child mode does not involve an attempt to threaten or intimidate. Therapists or others may at times feel intimidated or frightened by the intensity of the emotions seen in Angry Child mode; however, it is not the intention of this mode to threaten or intimidate, whereas it is the intention of Bully and Attack mode. Finally, the predator mode involves a cold, ruthless anger that is directed toward eliminating a threat, rival, enemy, etc. The Predator mode is more controlled and calculating than the Angry Child.

IMPULSIVE / UNDISCIPLINED CHILD MODES

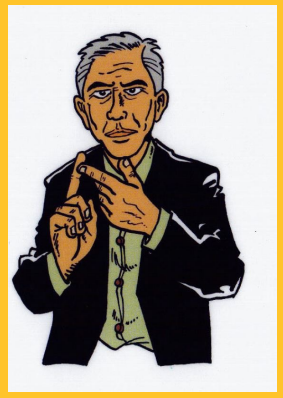
Impulsive, Undisciplined Child – acts like a spoiled child who "wants what he wants when he wants it," and can't tolerate the frus*tration of limits.*

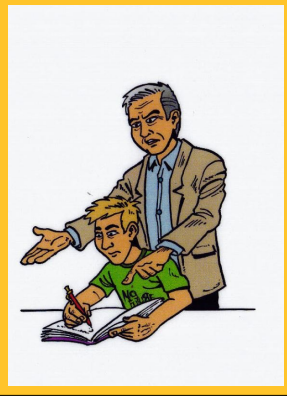
The impulsive child lacks patience. He wants what he wants *right now*, and becomes frustrated, angry, or agitated if he doesn't get it. His lack of frustration tolerance may be because he is spoiled, and feels entitled to get what he wants. Or, he may never have developed the capacity to postpone or delay, and therefore finds waiting intolerable. He has little tolerance when other people take their time, or don't respond rapidly on demand. He often acts without thinking first. His feelings can be translated immediately into action, with stopping to reflect about consequences. In his frustration, he may look for objects or persons to act on immediately, for example, throwing things, banging, breaking, hitting people, and so forth. Thus, he may switch rapidly from impulse child to angry child mode if his demands or needs for action are not immediately met. Although impulse child and angry child modes are often seen in conjunction with each other, they are different modes. The impulsive child may also present without anger. For example, he may speak rapidly or switch quickly from topic to topic, move quickly and frequently (e.g., getting up and sitting down again and again), and show restlessness, distractibility, and a general tendency to respond quickly to stimuli. He may also react impulsively in response to his felt needs, such as impulsively buying things he doesn't need, taking drugs or drinking when the opportunity is there, or engaging in promiscuous sex. He may lack the patience to engage in long-term planning, as indicated by starting projects but losing interest and quickly abandoning them, or shifting frequently from one plan to another.

The patient may show impatience towards the therapist. He may express impatience for the session to end, or become frustrated by having to listen to the therapist. He may push the therapist to give in to his demands. He has a hard time accepting boundaries, and therefore may feel that it is acceptable to pressure the therapist to give him what he wants, or do him special favors. He may become impatient or agitated when a therapist hasn't had the time to act on his request (e.g., complete a report), isn't immediately available (e.g., goes on vacation), or refuses to give in to his demands. He may make excessive claims on the therapist's attention and time, badger the therapist, or find it difficult to share the therapist's time with other patients.

DYSFUNCTIONAL PARENT MODES

- The punitive parent mode (punitive inner voice)
- The demanding parent mode (demanding inner voice)





PUNITIVE / CRITICAL INNER VOICE (PARENT MODE)

Punitive, Critical Parent – internalized, critical or punishing parent voice; directs harsh criticism towards the self; induces feelings of shame or guilt

The punitive parent makes itself manifest in the negative, critical, or self-punishing way in which the patient views himself and talks about himself. He may come across as dejected, inadequate, or defeated, telling the therapist that he isn't making progress, has no skills, feels like a failure, and will always be a failure. He may feel guilt and shame, as if he is the source of the problem, even when that is objectively not the case. Thus, he may have an exaggerated sense of responsibility when things go wrong.

He responds to compliments by denying or undoing them, reflectively pointing out his own deficiencies. He may report that he hears a negative, critical voice in his head that causes him to suffer. He is constantly aware of his flaws, which the punitive parent criticizes relentlessly. This is not a psychotic state, because the internalized voice is experienced as a part of the patient. However, it is an indication that the patient is in a punitive mode. This may also express itself in some patients as a general tendency to be critical, intolerant, and moralistic, which may directed towards others as well as toward the patient himself. In general, however, this is more likely to be self-directed in the therapy session. The patient may be so self- punishing as to experience any form of vulnerability or normal human fallibility as weakness.

DEMANDING INNER VOICE (PARENT MODE)

Demanding Parent – directs impossibly high demands toward the self; pushes the self to do more, achieve more, never be satisfied with oneself.

The patient experiences the demanding parent mode as a feeling of internal pressure to perform. He constantly feels that he has to do better, that he has to strive to achieve more, that he needs to set higher goals. He is always busy trying to live up to his own expectations. In contrast, the compliant surrenderer is busy trying to live up to the expectations of others. No matter how hard he tries, the demanding parent never feels satisfied that he has done enough. Thus, the demanding parent never makes it possible for the patient to feel satisfied with his progress, or to accept himself as he is without having to prove himself. In the therapy session, the patient may say that he isn't working hard enough, expresses dissatisfaction with his own progress. The demanding parent may also express itself as a general tendency to have too high standards, both for one self and others. Thus, he may put pressure on the therapist to do more, make more progress. However, this tendency is mostly self-directed. The demanding parent often compares the patient to other patients, viewing the other patients as doing better than he is.

In contrast to the punitive parent, which involves a critical, punitive voice, the demanding parent voice constantly exhorts the patient to do better or more. Thus, while the punitive parent is punishing, the demanding parent is pushing.

THE MODES IN THE COPING STYLES…

- The compliant surrenderer
- The detached protector
- The detached self-soother
- The over-compensator

COMPLIANT SURRENDERER MODE

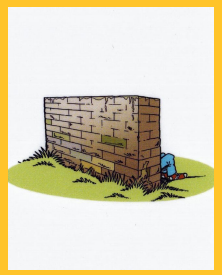
Compliant Surrenderer – Gives in the to real or perceived demands or expectations of other people in a anxious attempt to avoid pain or to get one's *needs met; anxiously surrenders to the demands of others who are perceived as more powerful than oneself.*

The compliant surrender attempts to please other people, and to go along with other people's perceived or real requests, needs, or expectations. He may be very eager for others to like and approve of him. He needs a great deal of reassurance that he is liked or worthwhile. Thus, the compliant surrender is driven by anxiety that others will leave, hurt, or dislike him, unless he makes excessive attempts to comply with others' needs or demands. The compliant surrenderer may be excessively focused on the needs and well being of others, to the neglect of his own needs. He may be exquisitely sensitive to other people's needs or feelings, but quite unaware of his own. He may experience himself as helpless or powerless without the presence of others, whom he perceives as more powerful than himself. Thus, he may attempt to ingratiate himself with others to gain the protection or support that he needs.

In the therapy session, the compliant surrenderer may be overly solicitous of the therapist's needs and emotional state. He may need constant confirmation, for example, by giving regular reports on his progress, which he expects the therapist to respond to with approval. He may tell the therapist how terrific he is, how much he trusts him, and how well he is progressing in the therapy. He may go out of his way to tell the therapist how much time he has been thinking about his last session, how insightful the therapist is. If the therapist has to miss a session or go on vacation, the compliant surrender will not complain, stating that, of course, the therapist has his own needs that sometimes come before those of the patient. However, the patient may actually suffer when the therapist is away, though he fears showing this openly. Sometimes the compliant surrenderer will not express feelings of disappointment or anger, feeling that they are not justified, or that the therapist might reject him if he were to express them openly. However, sometimes these feelings accumulate, and suddenly lead to outbursts of anger, either verbal or physical. More commonly, however, they manifest themselves indirectly in passive- aggressive ways, such as missing or being late for sessions, or talking behind the therapist's back to bring them into discredit.

DETACHED PROTECTOR MODE

- The reasonable, logical detached protector (often misinterpreted as the healthy adult mode)
- The intellectual detached protector
- The angry protector
- The Robot-Mode / the soldier Mode



DETACHED PROTECTOR MODE

Detached Protector – Uses emotional detachment to protect one from painful feelings; is unaware of his feelings, feels "nothing," appears emotionally *distant, flat, or robotic; avoids getting close to other people*

The detached protector may speak in an emotionally flat, distant, numb, or superficial manner, even when discussing apparently emotional topics. His voice may be monotone, his facial expression unchanging. Thus, there may be a disparity between the manner in which the patient expresses himself, and the topic over which he is speaking. The patient may appear tired, bored, or uninterested; he may choose topics that lack substance, and avoid emotionally laden ones. He may be overly intellectualized or concrete, or talk excessively about other people or the situation around him, but avoid talking about himself in a personal way. If asked about his week, he may respond that everything is fine, that nothing significant has happened, and that everything is the same as it usually is. The purpose of the detached protector is to make distance from people and to avoid painful situations or emotions. Thus, the patient may avoid interacting with people to whom he has strong emotional reactions. He may refuse to do experiential techniques that threaten to trigger strong emotions. When the patient is in detached protector mode, the therapist may experience feelings of boredom or frustration, because the session does not appear to be progressing. He may sense a lack of connection between himself and the patient. He may find that the patient denies feelings when asked about them, or that the patient responds concretely to such questions (e.g., describes thoughts or actions rather than feelings). Sometimes, the therapist may unconsciously adapt to the patient's detached protector by avoiding emotional topics himself, or conducting an overly intellectualized discussion with the patient.

ANGRY PROTECTOR MODE

Angry Protector – Uses a "wall of anger" to protect oneself from others who are *perceived as threatening; keeps others at a safe distance through displays of anger; anger is more controlled than in Angry Child Mode*

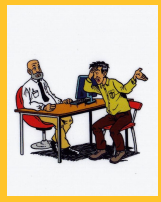
The Angry Protector shows his anger in an indirect, controlled manner. He may come across as sullen, sulking, hostile, or withdrawn. He may speak little, giving one- or two-word answers to questions, and making the therapist desperate to find topics that the patient will talk about. Although his facial expression, voice, and body language indicate that he his angry, he is unlikely to admit it. He does this for a reason, because it is safer to keep people at a distance. His non-verbal behavior sends a message to "stay away from me." His indirect hostility makes it difficult to confront the patient, or to empathize with him. Thus, the patient hides his vulnerability behind a wall of controlled anger. The patient's anger may come out in the form of snide, cynical, devaluing, or critical comments, or complaints. The therapist may feel that the patient is dissatisfied with him, or is impossible to please; at the same time, the detached protector gives the therapist little or no room to approach him more directly.

In contrast to the Angry Child, who vents anger openly, the Angry Protector communicates his anger only in an indirect manner, and strives to keep emotional distance.

THE DETACHED SELF-SOOTHER MODE

- Abuse of alcohol
- Abuse of Drugs
- Addictive behaviors to sexuality, playing computer games, etc....
- self-harm

THE COMPLAINING PROTECTOR MODE



THE STIMULATION / KICK SEEKING MODE

DETACHED SELF-SOOTHER MODE

Detached Self-Soother/Self-Stimulator – Uses repetitive, "addictive," or *compulsive behaviors, or self-stimulating behaviors to calm and sooth oneself; uses pleasurable or exciting sensations to distance oneself from painful feelings.*

The detached self-soother tries to sooth and calm himself through repetitive, compulsive, or addictive behaviors, such as drug or alcohol use, gambling, eating, shopping, sex, self-mutilation, and so forth. Thus, the detached protector seeks a pleasant physical state of buzz, high, excitement, thrill, or euphoria, in order to keep unpleasant or painful feelings away. The scorer may be tempted to rate this mode whenever the patient is talking about addictive behaviors. However, the patient may be in modes other than detached self-soother when describing his addictive or compulsive activities. For example, he may describe addictive behavior in an emotionally detached way (i.e., detached protector mode), or in an emotionally vulnerable way where he expresses painful feelings (i.e., vulnerable child mode). Thus, what is important in rating this mode is to describe the state the patient is in at the present time – that is, in the session itself. For example, the patient may talk about his drug use with evident pleasure, as if he is re-experiencing pleasurable feelings he associates with drug use. He may tell sexually provocative stories or fantasies in an effort to stimulate himself (and possibly his therapist) during the session. He may act seductively towards the therapist as a form of self-stimulating "entertainment," rather than having to focus on painful or personal topics. He may tell stories about his past acts of violence, to generate a sense of satisfying excitement. The detached protector may manifest itself in more subtle ways, for example, in stroking himself on the arm, picking at his skin, pulling on or twirling his hair, biting his lip or nails. He may suddenly experience the urge to have a cup of coffee, or to have something sweet to eat. He may begin to day dream about some pleasant fantasy, where he suddenly feels far away from the present. He may begin to experiencing cravings or urges in the session itself, although patients often will not report this to therapists, unless they are asked.

COMPLAINING PROTECTOR MODE

Complaining Protector – complains, whines, and demands in a victimized, dissatisfied manner; expresses his dissatisfaction in an off-putting manner that masks his real feelings and needs

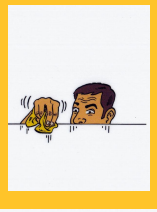
The Complaining Protector complains or whines about situations over which he feels a sense of helpless, but dissatisfied, victimization. For example, he may complain about his physical ailments, and his futile attempts to get them treated. He may complain that doctors have little patience with him, don't take his complaints seriously, see him as a nuisance, or are incompetent. He expresses his complaints in a manner that implicitly or explicitly expresses a sense of victimization. The implication is that others are not doing enough to help, yet the listener may often be left with the feeling that the patient is never satisfied. Paradoxically, the patient's complaining draws attention to his suffering, but often leaves people with the feeling that they are incompetent to help him. The patient's complaining thus keeps others at a distance. The Complaining Protector doesn't show his emotional pain in an open manner, as in Vulnerable Child mode. Instead, the emotion in Complaining Protector mode is expressed indirectly, as irritation, frustration, helplessness, or resignation. The feeling is one of "poor me."

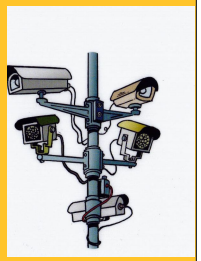
The Complaining Protector bears some similarity to the Angry Protector mode. In the Angry Protector mode, the therapist senses in the patient a smoldering, though controlled, hostility that keeps the therapist (and others) at a safe distance. For example, patients in Angry Protector mode often feel mistreated, and may complain bitterly about the unjust way in which they are being punished, the privileges they are being denied, and so forth. The patient's affect is one of controlled or suppressed anger directed at the person who is mistreating him. In the Complaining Protector mode, on the other hand, the patient's neediness is more apparent than in the Angry Protector mode. He seeks help, but at the same time, rejects it. His affect may include feelings of anger and victimization, but usually also includes feelings of neediness, helplessness, and self-pity.

THE OVER-COMPENSATION

- The Bully & Attack
- The self-aggrandizer
- The conning / manipulative mode
- The over-controlling mode
- Killer-Mode





BULLY & ATTACK MODE

Bully and Attack Mode – uses threats, intimidation, aggression, or coercion to get what he wants, including retaliating against others, or asserting ones dominant position; feels a sense of sadistic pleasure in attacking others

Patients in bully and attack mode threaten or intimidate others in obvious or more subtle ways. For example, a patient may say that he has a weapon and that he is planning to use it against someone (usually unspecified) in the clinic. He may say that the family members of a treatment provider he doesn't like better be worried. He may raise his voice, stare, point his finger, or interrupt the person whom he is speaking with, to make his point in an intimidating way. He may speak in a loud or out of control manner, get up and pace around the room, suddenly throw objects or slam doors, to make the point that he is angry and that he is someone not to be ignored. The purpose of these displays of anger is not just to ventilate or express frustration as in Angry Child mode. In Bully and Attack mode, they serve to put the therapist on notice that he ought to be careful of whom he is dealing. Thus, they convey the impression that the patient could become dangerous, and that the therapist better be careful of what he says and does. The patient may attempt to find the therapist's weak points, speaking in denigrating ways about the therapist's personal appearance, personality traits, or events that he knows about from the therapist's life. In contrast to Self-Aggrandizer mode, where the purpose is to make the other person feel inferior, in Bully and Attack mode, the purpose is to cross a boundary so that the therapist feels unsafe or powerless. Thus, the patient tries to gain the upper hand by attacking the therapist's character. When the therapist empathizes with him, the patient may suddenly turn against the therapist, saying pointedly that the therapist has the privilege of leaving the institution, while that he, the patient, cannot, and that the therapist has no idea of how bad it is to be incarcerated. Again, the purpose here, unlike in Angry Child mode, is not just to ventilate frustration; instead, in Bully and Attack mode, the purpose is to keep the therapist off-balance, to leave him feeling that he is "walking on egg-shells," to the point where the therapist may feel afraid every time he considers speaking to the patient. The patient may challengingly ask the therapist what he plans to say about the patient at his next hearing, not simply to inquire, but to put the therapist on notice that he better have good things to say about the patient. The Bully and Attack mode may be evident not only in how the patient interacts with the therapist; it may arise when the patient describes his interactions with other staff members, patients, family members, and so forth. For example, a patient may boast about how he told off a staff member, reveling in how he intimidated or verbally abused the person. There may be an element of Self-Aggrandizer mode in such stories, which present the patient as powerful and superior, and the staff member as stupid, weak, and inferior. However, they can be scored also for Bully and Attack mode if the patient shows the side of himself that uses threats, attacks, or intimidation to put someone else in his place.

SELF AGGRANDIZER MODE

Self-Aggrandizer Mode – feels superior, special, or powerful; looks down on others; sees the world in terms of "top dog" and "bottom dog" shows *off or acts in a self-important, self-aggrandizing manner; concerned about appearances rather than feelings or real contact with others.*

The self-aggrandizer mode likes to present himself in a positive light. He spends a lot of time on his appearance. He tells stories that highlight his specialness. He views himself as superior to others. He feels that he is deserving of special treatment or attention. He feels that the normal rules do not apply to him. He sees himself as an expectation to the normal rules. He can be quite arrogant and devaluing towards others. He puts himself above other people, seeing people in terms of superior and inferior. He finds the idea of being ordinary abhorrent. He likes to talk a lot about himself, focusing on his successes, or on his special personal attributes. He has a marked lack of self-criticism. On the other hand, he easily finds fault with others. He may be very devaluing and critical towards his therapist. However, sometimes he may feel that he and the therapist share a special bond, that they are both special people who are superior to others. The patient may see himself as no ordinary patient. He may tell the therapist or other patients that they can learn a lot from him. He may tell the therapist that he (the therapist) is lucky to have the patient on his caseload. Sometimes the self-aggrandizer may manifest itself more subtly. For example, if the patient has sufficient self-awareness, he may know that blatant self-aggrandizement can make a negative impression. However, his innuendoes make it obvious that he sees himself as superior to others. In more subtle or obvious ways, he wants to dominate or control others, including his therapist. Thus, he make dictate the choice of topics to be discussed, or make it difficult for the therapist to confront him. He is sensitive to the power relationships between people, and needs to assert his dominance when he feels that others are getting the upper hand.

CONNING & MANIPULATIVE MODE

Conning and Manipulative Mode - cons, lies, or manipulates in a manner designed to achieve a specific goal, which involves getting what he wants, victimizing others, or escaping punishment.

In contrast to Bully and Attack mode, which involves direct threats or intimidation (either overt or subtle), in Conning and Manipulative mode, the patient uses indirect methods to get what he wants. The patient may claim to help other people, express sympathy for others, have empathy for the therapist, or present himself as kind, caring, and understanding, in order to curry favor with the therapist. The patient may use or manipulate other patients who are weaker or more vulnerable than he is, for example, asking other patients to do him illegal favors (e.g., hiding drugs in their room), or keep secrets for him. The patient may also spread rumors about others, for example, claiming that another patient is gay or having emotional problems, or that a therapist is having a sexual relationship with a patient. The patient may seek information that he can use against someone, or probe for emotional weak points that he can use to blackmail or manipulate others. The patient may claim to be privy to confidential information about others, in order to trick other people to share confidential information with him. The patient may make up stories about his misfortunes to make others sympathetic to him. The patient may dress in a provocative or inappropriate way in order to provoke a reaction in others (e.g., to gain attention, or to divert attention from other, more emotional issues). The patient may attempt to form a special bond with the therapist, for example, by speaking in a local dialect with him or her, or claiming to share certain interests or a common background. The patient may use the therapist's sympathy for him to get special favors, like getting the therapist to give him his home telephone number, to intervene for him with other staff members, or to change his report in ways that present the patient in a favorable light. The patient may offer to trade favors with the therapist, like agreeing to do something or make something for the therapist (e.g., making a painting for the therapist), if the therapist gives him something in return. In some cases, the patient may do the therapist unasked favors, like bringing a cup of tea or some candy for the therapist, to create a feeling of good-will or obligation. This is different than in the Compliant Surrenderer mode, where the patient is genuinely concerned about the therapist's approval of him, and is bending over backwards to be a "good" patient. In Conning and Manipulative mode, the patient has learned the adage, "I'll scratch your back, and you'll scratch mine."

PREDATOR MODE

Predator Mode - focuses on eliminating a threat, rival, obstacle, or enemy in a cold, ruthless, and calculating manner.

The patient in Predator mode seems cold and unreachable, or too calm and under- reactive. He treats others like objects to be used, pushed aside, or destroyed, rather than as human beings. The violence of the Predator is typically cold and calculated. For example, a patient may spend several weeks secretly planning an attack or making a weapon, which he then uses against his victim, either to get rid of him, to take revenge, or to demonstrate his power to others. In contrast to Bully and Attack mode, which involves attempts to threaten or intimidate, the patient in Predator mode simply wants to take care of business, to handle a situation that he finds unacceptable. For example, a patient may take a staff member hostage, not to frighten him, but to gain access to something he wants (e.g., letting the hostage go free, in exchange for being allowed to leave the institution). Similarly, a patient may decide to attack another patient who has been behaving seductively towards him, not because he is enraged, but because he finds the other patient's behavior unacceptable and has decided that it must be stopped. Thus, the purpose is to gain an objective, rather than to frighten someone (e.g., Bully and Attack mode), or to give expression to anger (e.g., Angry Child mode). The victim is treated as an object to be used for a particular end, or if necessary, to be eliminated. In contrast to Angry Child mode, where the patient's rage may lead him to attack someone, the aggression in Predator mode is cold and mechanical. When in Predator mode, the patient's eyes may look blank and empty, his face immobile and expressionless. In contrast, in Bully and Attack mode or in Angry Child mode, the patient's angry and aggression are more visible, his expression more lively. While Predator mode is often involved in calculated forms of violence, patients may also suddenly flip into Predator mode, if something unexpected triggers them. For example, a patient may suddenly get a blank expression in his eyes, begin to talk or act in a strange and frightening manner, not to achieve the effect of intimidating others, but because he was offended or threatened by something that has occurred, and is preparing to respond aggressively. Predator mode can often be seen in patients who have histories as enforcers or hired killers. They may describe their work as "just business" or "nothing personal." The may claim to have no feelings or regrets about they have done, or blame their victims (e.g., for provoking them).

OVER-CONTROLLER MODE

Over-Controller Mode (Paranoid and Obsessive-Compulsive Types) – attempts to protect oneself from a perceived or real threat by focusing attention, ruminating, and exercising extreme control. The Obsessive type uses order, repetition, or ritual. The Paranoid type attempts to locate and uncover a hidden (perceived) threat.

The patient in Paranoid Over-Controller mode is sure that others have ill intentions, and is always on the look out, because nothing is what it seems. He easily misinterprets the behavior of others, and has a tendency to focus on small details, misreading them and coming to the conclusions that others are out to hurt him or humiliate him. For example, a patient may notice that his therapist raised an eyebrow, and conclude that the therapist is mocking him. He may notice that the therapist picks up a pen, and become concerned, wondering what the therapist is up to. The patient may combine unrelated bits of information, weaving a story about others malevolent intentions toward him. For example, he may notice a smudge on a photograph, and a red mark on it, and conclude that someone has placed a curse on him. The patient in Paranoid Over-controller mode may ruminate about perceive hurts or injustices that others have done to him, revisiting these episodes and plotting revenge. The patient in this mode is often vigilant to possible threats around him. He may insist on sitting in a corner of the room where no one can sneak up on him. He may refuse to be alone in a room with a door that cannot be locked, or to take a shower with a closed curtain. The patient make go to considerable effort to discover who is out to get him, seeking information, often based in small details, that will reveal the identity of his enemies.

The Obsessive Over-controller uses order, detail, ritual, or repetition to cope with anxiety-provoking or threatening situations. In therapy sessions, patients with an Obsessive Over-controller often tell stories in mind numbing detail. They include many more details than are actually needed, or get so caught up in the details that the main thread of the story is lost. At times, the story can have a pressured quality, as if the patient needs to tell it "just right," or exactly as it happened. The patient may become upset if the therapist attempts to interrupt before the story is finished. In some cases, the mode may dominate the therapy session, as when a patient spends an entire session describing a difficult situation in minute detail (e.g., "I said..., then he said, ..., then I said..."), making it difficult or impossible for the therapist to break in. The therapist may sense the patient's underlying anxiety, which the patient attempts to control through the obsessive telling of the story. While the patient is in this obsessive mode, he is often not aware of his underlying anxiety, or of the effect that this side of him has on his listener.

The Obsessive Over-controller may manifest itself in other ways, for example, through the use of obsessional rituals, such as counting or checking. For example, one patient, when worried, would comfort himself by thinking of his "lucky" numbers. The Obsessive Over-controller may also manifest itself by an excessive devotion to certain topics, such as work, where the patient can feel "in control." For example, the patient may prefer to spend the session talking about the details of his working life, rather than other areas (e.g., family, relationships) where he feels less in control. When the Obsessive Over-controller mode is extreme, the patient may appear to be overly intellectual, under rigid self-control, speaking deliberately or precisely, lacking spontaneity, or cut off from his feelings.

Obviously, the Obsessive Over-controller bears some similarity to the Detached Protector mode, which also involves an avoidance of emotion. However, the Over-controller involves an obsessive focusing on detail, where the Detached Protector does not. The Detached Protector may tell a story in a mechanical, robotic, or unemotional way, but the amount of detail included is not greater than average. Moreover, in the Obsessive Over-controller, the underlying feeling is one of pressure or anxiety; in contrast, in the Detached Protector mode, there is an emotional numbness or absence of feeling. Of course, these two modes may be present in some of the same patients.

HEALTHY ADULT MODE

- This is the mode, which we seek to strengthen during therapy, by teaching the patient to moderate, support or heal the other modes.

HAPPY CHILD MODE

HEALTHY ADULT MODE

Healthy Adult Mode – reflects on himself and his situation in a balanced, realistic manner. Is aware of his needs and feelings; realistically appraises situations and considers how to get his needs met in a productive, appropriate, and adaptive manner.

The healthy adult is able to look at situations in a balanced way. He is able to integrate thoughts and feelings, so that he is not just using his intellect or his emotions in an extreme or rigid way. He is able to take different perspectives on a situation, including looking at situations from the perspective of another person. Thus, he is able to say, for example, "I can imagine that from her perspective it looks different..." He is able to make room for feeling and expressing emotions, but also to take distance from them in a healthy way. Thus, he moves back and forth from experiencing to reflecting. In contrast, the detached protector mode involves a rigid and immediate distancing from feelings. The healthy adult also involves a realistic appraisal of situations. For example, some patients may have unrealistic views about their future, stating that it will be no problem to find a job, start a family, or avoid problems. Patients with a healthy adult mode are more realistic about their strengths and weaknesses, and can anticipate problems and therefore make realistic plans for the future. For example, a patient may say that his past problems were just due to drug or alcohol problems, or from hanging out with the wrong kinds of friends, or choosing the wrong kind of partner. Thus, he has difficulty in recognizing that some of these difficulties lie in himself. These patients may make statements like, "I'm not doing drugs any more, so it won't be a problem for me to keep a job or avoid crime in the future." These patients have a tendency to externalize, minimize or deny problems, and distance themselves from their feelings. They may believe that they are engaging in healthy behavior. However, their approach indicates the presence of some kind of protector mode (e.g., Detached Protector, Over-controller, Self-Aggrandizer). On the other hand, patients in the healthy adult mode can acknowledge the part of themselves that is scared or has concerns about the future. Thus, the healthy adult is aware of and in contact with the vulnerable side of himself, and acknowledges his fears or feelings of inadequacy.

HAPPY CHILD MODE

Playful Child Mode – acts in a playful, fun-loving, free and spontaneous manner; experiences genuine pleasure in people or activities; is open in the expression of his joyful feelings.

In the therapy session, the playful child can show spontaneous, playful behavior in an appropriate way. For example, making jokes, laughing with the therapist, or laughing about a situation can all be examples, so long as they are done with genuine good will and a sense of humor about oneself as well as others. On the other hand, humor whose purpose is to hurt or belittle others, or to avoid dealing with real feelings, does not indicate a playful child. Rather, it indicates the presence of a self-protective mode, such as bully and attack, self-aggrandizer, or detached protector. Thus, this humor is more cynical, sarcastic, or devaluing. The playful child is often present at the beginning of the session, if the therapist and patient have a good bond and feeling of mutual trust. The patient may tease the therapist in a playful way about how she drinks her coffee, or her new hairstyle, and so forth. There is genuine affection and mutual positive regard in such interactions; thus, a sense of playful sharing and caring for one another that emerges in small ways. The playful child enjoys sharing his interests or activities with others. For example, a patient may enthusiastically talk about or show the therapist the latest drawing he has made, computer game he has learned, pictures of the family, or the film he has seen. These moments may move from enthusiasm and pleasure, shared in an open and spontaneous way (Playful Child) to more serious reflection of what such activities mean to him (Healthy Adult mode). The therapist and patient may discover that they share mutual interests, for example, discussing with enthusiasm the latest episode of a reality TV program. While the playful child can be very enthusiastic, laughing, smiling, and sharing in a fun and mutual way, he rarely shows the extremes or recklessness of the Impulsive Child. The Impulsive Child sometimes gets carried away with his enthusiasm. He wants what he wants now, or is unstoppable, even when his emotions get out of hand. Thus, he may transgress boundaries, insist on having what he wants immediately, behave in a chaotic or disorganized way, or show bad judgment in acting on his impulses. In contrast, the playful child has more appreciation for the feelings, needs or rights of others. If the patient goes too far in his joking, he will quickly notice the therapist's reaction, and stop, inquire, or apologize. The Impulsive Child is essentially egocentric. He is too caught in what he is doing, in his own impulses or desires, to take account of how they are affecting others. The playful child is engaged in play and fun that is essentially mutual. There is a shared sense of fun and thus also a sense of appropriate limits and sensitivity towards the other person. This mutual fun can help to lighten some of the serious moments of human interaction. For example, the patient may make fun of himself when he persists in doing something that he and his therapist have agreed is not productive. Thus, the therapist and patient can laugh together about human foibles.

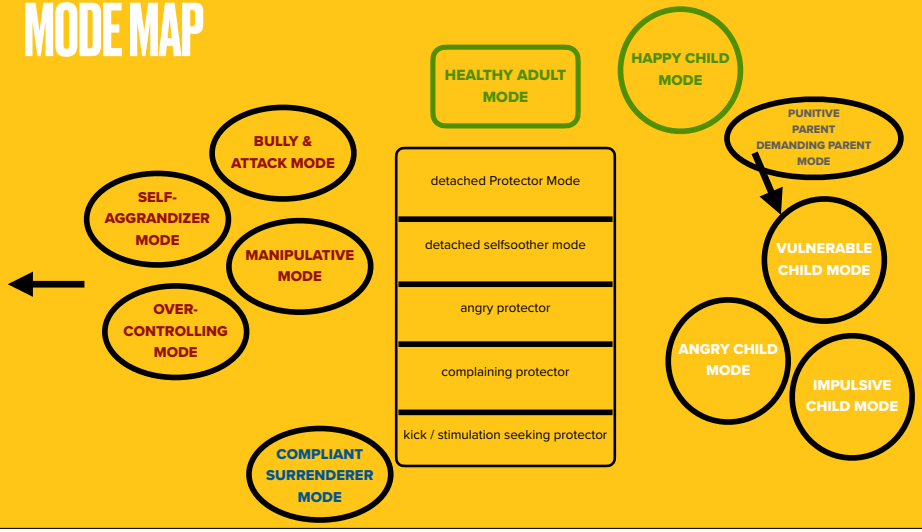
MODE-CARDS DE PROF. DAVID BERNSTEIN:

WWW.I-MODES.COM

INTRODUCE THE MODES (REMCO – STEP BY STEP)

DISCUSSING THE MODE MODEL (STEP BY STEP – MARJON)

MODE MAP



SPEAKING OF MODES...

- „it's a part of you..."
- "it's a side of you..."

GENERAL STRATEGIES IN WORKING WITH MODES

- to identify the modes, which block the progress of the client
- to identify the concrete thoughts, feelings, behavior of the mode
- discuss the origins of the patterns and their functions
- discuss the advantages of the modes
- validate the modes
- discuss the disadvantages of the modes
- use role-playing, mode-cards, mode-model

SCHEMA THERAPY ACADEMY
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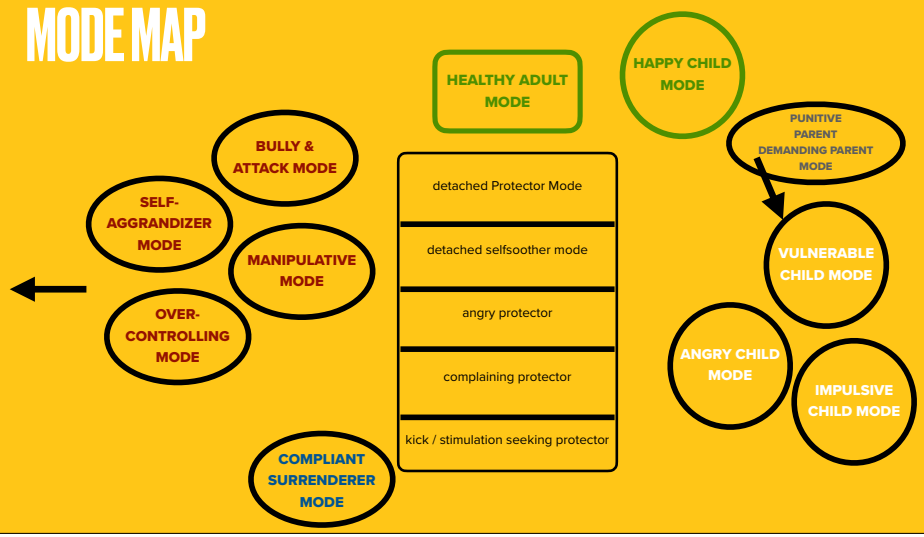
HTTPS://
WWW.UPGRADEYOURLIFE.LU/
THE-SCHEMA-THERAPY-ACADEMY/
BODY-FOCUSED-INTERVENTIONS-
IN-SCHEMA-THERAPY/

ALSO POSSIBLE TO ATTEND ONLINE IN GROUPS OF 2

MODE MAP



WHAT MODE IS THIS?

Video David Bernstein

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EXERCICE: MODE MODEL

- Groups of 2
- each person makes a Model for a client and explains the Model to your partner
- 30 minutes

MODES IN ANTISOCIAL PERSONALITY

- Humiliated Child, the Abused Child, the Abandoned Child
- the Angry Child
- the Impulsive Child
- the Angry Protector
- the Detached Protector
- the Detached Self-Soother
- the Bully & Attack

MODES IN THE PSYCHOPATHIC PERSONALITY

- the Humiliated Child, the Abused Child, the Abandoned Child
- the Angry Child
- (the Impulsive Child)
- the Angry Protector
- the Detached Protector
- the Detached Self-Soother
- the Bully & Attack
- the Self-Aggrandizer
- the Manipulator
- Killer-/Predator-Mode

TREATMENT PHILOSOPHY

- motivate the patient by focusing on the modes, which block the therapeutic progress
- reduce the pain of the vulnerable child
- help the impulsive child to deal with frustration
- help the angry child to express anger in different degrees and express it more constructively
- to reduce the frequency of unhelpful modes, to help the patient to show his vulnerable side and to establish emotional connection
- strengthen the healthy adult, so that he/she thinks before reacting and can make positive choices

FIRST STEP: THE THERAPEUTIC ALLIANCE AND THE EMOTIONAL REGULATION

- create a connection with the client
- bypass the Detached Protector
- "reparent" the Abandoned Child

IT IS REALLY IMPORTANT TO RECOGNIZE HOW THE DETACHED PROTECTOR BLOCKS ACCESS TO THE VULNERABLE CHILD

IF WE ARE NOT ABLE TO BYPASS THE DETACHED PROTECTOR WITH A CLIENT, SCHEMA THERAPY IS NOT GOING TO BE A SUCCESS NORMALLY.

WE WILL BE UNABLE TO ACCESS THE VULNERABLE CHILD, OR THE UNMET CORE EMOTIONAL NEEDS.

RECOGNIZE THE DETACHED PROTECTOR::

- client complains of not feeling anything
- look for "non-verbal" signs: flat affect, rigid posture, no eye contact, distant towards therapist
- behavior outside of therapy sessions: addictions, cutting, too much internet surfing, isolated & avoiding contact
- Therapist reactions to client: boredom, fatigue, difficulty concentrating, frustrated...
- Results of the schema questionnaires (YSQ, SMI, YPI)

GENERAL STRATEGIES IN WORKING WITH THE DETACHED PROTECTOR

- stay curious and ask a lot of detailed questions about the emotions of the past
- don't let the client avoid too easily - think of yourself as an emotional detective (Columbo, J.B. Fletcher, Miss Marple,...)
- not be too confrontational, appear curious
- validate positive experiences with parents
- reach out to clients, self-disclosure, if authentic and appropriate

GENERAL GOALS IN WORKING WITH THE DETACHED PROTECTOR

- explaining the detached protector, its development and function
- by creating trust, reassuring the detached protector, that the therapist will help the client to contain and soothe the emotions
- bypass the detached protector (usually with emotionally focused techniques) to access the vulnerable child, the angry child & the punitive parent
- offer intense limited reparenting for the vulnerable child

AFTER THE FIRST FEW MONTHS ALMOST EVERY SESSION IN WHICH THE CLIENT REMAINS IN THE DETACHED PROTECTOR IS A "LOST" SESSION!

Jeffrey Young

FILM: DETACHED PROTECTOR IDENTIFYING MODES

2 PHASES OF SCHEMA THERAPY

- Diagnostic & Psychoeducation & Bonding th. Rel.
- Change
- Autonomy

GENERAL STRATEGIES TO CHANGE SCHEMAS

- cognitive: restructuring schema-related thinking, developing healthy adult voice
- Emotional Focusing: practicing experiential exercises to vent anger, grieve past pain, encourage the patient
- Therapeutic Relationship: pay attention to the therapeutic relationship to help with limited reparenting and to soothe the schemas and coping styles triggered in the sessions
- stopping patterns through behavioral interventions: practicing behavioral and interpersonal changes related to the presenting problem; breaking dysfunctional patterns

EXPERIENTIAL STRATEGIES FOCUSED ON EMOTION: :

- limited reparenting
- imagery rescripting
- empathic confrontation
- chair-work
- ...
- look at examples...

CASE CONCEPTUALIZATION

https://www.schematherapysociety.org/new-conceptualization-form

- CC important to do for each case
- important for the certification
- there is also an filled in example on the ISST website

LET'S HAVE A LOOK AT THE FILLED IN EXAMPLE

I. CASE CONCEPTUALIZATION

What you can do…

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CASE CONCEPTUALIZATION

1. to conceptualize we need...
2. Diagnostic imagery
3. Prof. D. Bernstein's Modes Model
4. Case Conceptualization for Certification!!!

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WE NEED INFORMATION!

- identify core problems and symptoms
- Which core emotional needs were not being met?
- Is the client well suited for schema therapy?
- acute axis I symptoms (psychosis, depression, panic,...)
- severe substance abuse
- serious life crisis

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IDENTIFY THE PATTERNS

- to explore one's life story
- the Genogramm
- The river of life

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IDENTIFY THE LIFE PATTERNS

- look for Life Patterns related to current problems, such as partner selection (schema chemistry), work problems, relationship conflicts...

PSYCHOEDUCATION

- explain the concept of core emotional needs, schemas and patterns
- ask to read the introductory chapters of "reinvent my life

EVALUATE THE QUESTIONNAIRES

- Young Schema Questionnaire (YSQ-L3)
- Young Parenting Inventory (YPI)
- Schema Mode Inventory (SMI)

USING THE RESULTS OF THE YSQ-L3

- assess the YSQ-L3 and discuss the results with the client
- relate the high schemas to the client's current problems; determine with the client which schemas are most central to the client's current difficulties
- ask the client to read chapters in "Reinventing My Life" on which the client received high scores

ASSESSMENT OF THE ORIGINS DURING CHILDHOOD & ADOLESCENCE

- discuss the client's memories of their past
- have the client complete the Young Parenting Inventory
- relate parenting behavior to coping patterns and behaviors

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EMOTION-FOCUSED TECHNIQUES FOR THE ASSESSMENT OF SCHEMAS AND MODES

Diagnostic imagery (1):

- look for a situation that has been difficult for the client in the last few weeks (sad situation, angry situation,...)
- explore the very concrete context to activate the emotions
- explore the thoughts, body sensations and emotions connected to this situation

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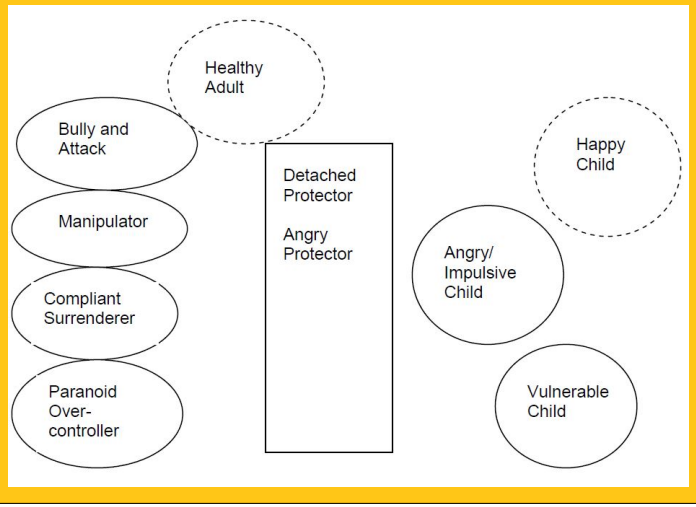
DIAGNOSTIC IMAGERY (2)

- if the emotion is activated strongly enough, we let the present image disappear and let the client go to the past (without actively looking for something)
- if an image from childhood/adolescence appears (with father, mother,...) we want to know what is going on in this situation,
- to ask the client, what he needs from the important people in this situation
- it is important to really understand the child's need in this imagination
- after the imagination, debrief with the client: connect the emotions of the past with the present problems; connect the images of the childhood with the present situation with schemas and patterns

MODE MAP



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II. THE THERAPEUTIC RELATIONSHIP

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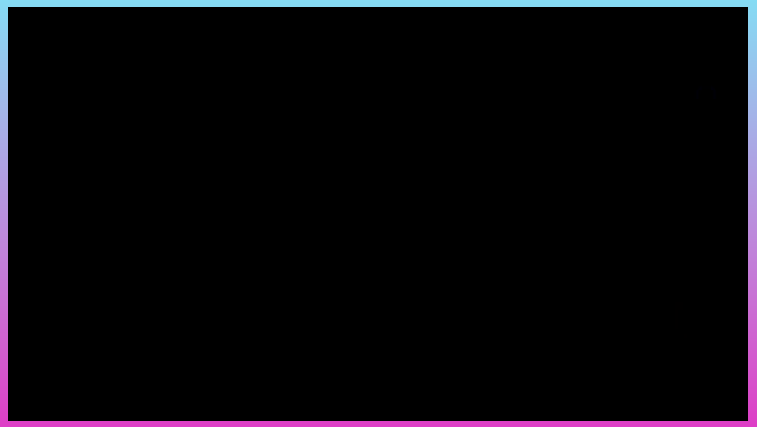

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ATTACHEMENT

- Jeffrey Young was influenced a lot by Bowlby's attachment theory
- Young's central idea for ST:
- "The primary origins of most personality disorders are core emotional needs not adequately met during childhood and adolescence, especially needs related to parenting."

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CORE EMOTIONAL NEEDS

- secure attachment, stable base
- protection from abuse and injury
- affection, attention
- feeling accepted and appreciated
- empathy
- autonomy
- validation of emotions and needs
- realistic limits

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NEEDS & ATTACHEMENT

- when children's core emotional needs are not adequately met, they will very often develop problems with secure relationships afterwards
- most of our clients with personality disorders, such as BPD, NPD, APD have serious problems with attachment and relationships in adult life

UNIVERSAL QUESTIONS FOR ATTACHMENT

- can I count on you and trust you?
- Are you there for me?
- Will you respond to me if I need you?
- am I important to you?
- do you like/accept me?

AND THESE QUESTIONS ALSO COUNT IN THE THERAPEUTIC RELATIONSHIP

THERAPEUTIC RELATIONSHIP

- for the schema therapist, the therapeutic relationship is an indispensable element in the diagnosis and change of schemas
- the therapeutic relationship will be used in the diagnostic phase and in the change phase

THERAPEUTIC RELATIONSHIP IN THE DIAGNOSTIC PHASE

1. **therapist establishes the collaborative relationship**
2. **therapist conceptualizes the case**
3. **therapist identifies client's re-parenting needs**
4. **qualities of the ideal schema therapist**

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1. THE THERAPIST ESTABLISHES THE COLLABORATIVE RELATIONSHIP (1)

- empathy, warmth, authenticity
- establishing a welcoming and secure context in which the client can form an emotional bond with the therapist
- schema therapists are natural, rather than detached and distant
- they let their natural personality shine through
- they share their emotions, if this will have a positive effect on the client's situation

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1. THE THERAPIST ESTABLISHES THE COLLABORATIVE RELATIONSHIP (2)

- asking for feedback about the therapist and treatment - often !!!!
- encourage clients to express their negative feelings about therapy
- we will try to listen without trying to defend ourselves, we want to understand the client's point of view
- the therapist forms an alliance with the client's healthy side against the client's schemas
- the final goal of the treatment is to strengthen the client's Healthy Adult mode

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2. THE THERAPIST CONCEPTUALIZES THE CASE (1)

- the therapeutic relationship uncovers the client's (and the therapist's) schemas and coping styles
- when a schema is activated in the therapeutic relationship, the therapist helps the client to identify it
- by exploring together with the client, what actions of the therapist activated the client's schemas
- what were the client's thoughts, emotions, actions with the schema

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2. THE THERAPIST CONCEPTUALIZES THE CASE (2)

- what was the client's coping response (submissive, avoidant, overcompensating???)
- we use imagination to help the client relate this incident to his childhood

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THE SCARF AS AN AID TO SHOW THE CONNECTION BETWEEN THERAPIST & CLIENT

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3. THE THERAPIST DETERMINES THE NEED OF THE CLIENT'S RE-PARENTING

- for the limited re-parenting during the treatment it is necessary to know, which are the core emotional needs not enough fulfilled in the client
- to determine the emotional needs of the client the therapist uses different sources: family history, interpersonal difficulties, questionnaires, imagination work, behavior of the client in the therapeutic relationship...

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4. THE QUALITIES OF THE IDEAL SCHEMA-THERAPIST

- The ability to adapt and remain flexible is very important
- the therapist must adapt his or her style to match the emotional needs of the client: generate trust, provide stability, help to grow emotionally, encourage independence, ...
- He or She must provide through the therapeutic relationship everything that can serve as a partial antidote to the client's Schemas

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4. THE QUALITIES OF THE IDEAL SCHEMA-THERAPIST (2)

- to be more like a good parent and like the good parent the therapist is able to meet - within the limits of the therapeutic relationship - the core emotional needs of the client
- the therapist is the role model, from whom the client can learn how the healthy adult deals with emotions, problems, life...

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4. THE QUALITIES OF THE IDEAL SCHEMA-THERAPIST (3)

- the schema therapist can tolerate and contain strong emotion in the client
- the therapist has realistic expectations of the client
- the therapist sets limits to his/her own and the client's behavior
- is able to handle crises appropriately in session
- he or she maintains an appropriate distance between himself and the client, neither too close nor too far
- the therapist must also determine whether the therapist's own schemas are not an obstacle to the therapy

no, no, no… :)

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CRITERIA FOR CERTIFICATION

_____ 2. COMPRÉHENSION ET HARMONISATION

0 Le thérapeute a échoué à plusieurs reprises à comprendre ce que le patient disait explicitement et est donc constamment passé à coté du sujet. Très faibles compétences empathiques.

2 Le thérapeute a généralement été en mesure de refléter ou de reformuler ce que le patient disait explicitement, mais il a omis à plusieurs reprises de répondre à une communication plus subtile. Capacité limitée à écouter et à faire preuve d'empathie.

4 Bonne capacité d'écoute et d'empathie. Le thérapeute semblait généralement saisir la «réalité interne» du patient, tel que reflété par ce que le patient disait explicitement et ce qu'il communiquait de manière plus subtile.

6 Excellente capacité à comprendre et à faire preuve d'empathie. Le thérapeute semblait pleinement comprendre la «réalité interne» du patient et il a été habile à communiquer cette compréhension au patient à travers des réponses verbales et non verbales appropriées (par exemple, le ton de la réponse du thérapeute était en syntonie avec l'état émotionnel du patient).

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CRITERIA FOR CERTIFICATION

6 La collaboration semblait excellente. En plus de s'accorder sur les objectifs et d'avoir une très bonne alliance, le thérapeute encourageait le patient autant que possible à prendre un rôle actif lors de la séance (par exemple, en offrant des choix), et ils pouvaient ainsi travailler en équipe. Le thérapeute a été capable de solliciter des commentaires, en percevant la manière dont le patient répondait à la séance, et en ajustant sa démarche de manière à favoriser la collaboration.

6 Le thérapeute est excellent à maintenir un style thérapeutique équilibré et montre un niveau optimal de flexibilité en adaptant son style aux besoins et aux sentiments spécifiques de ce patient tout au long de la séance.

6 Le thérapeute montre des niveaux optimaux de confiance en soi, d'aisance et de d'assurance en ses ressources. Il fournit une direction utile à la séance et le fait de manière confortable. Le thérapeute semble particulièrement naturel et spontané, étant lui-même au lieu de sembler suivre les « règles» de ce qu'un bon thérapeute devrait être ou faire.

_____ 13. UTILISATION DE LA RELATION THÉRAPEUTIQUE DANS LE CHANGEMENT

Le thérapeute remarque lorsque des schémas, des styles d'adaptation, ou des modes sont activés par la relation thérapeutique elle-même, puis utilise la relation comme un outil dans le changement de schémas. Le thérapeute se concentre sur les interactions entre le thérapeute et le patient dans le «ici et maintenant», pendant la séance.

S.O. La relation du patient avec le thérapeute ne semble pas être une question qui a été déclenché ou soulevée lors de la séance. Le thérapeute a eu raison de ne pas se concentrer directement sur la relation thérapeutique.

0 La relation thérapeutique semblait être un problème pendant la séance, mais le thérapeute soit n'a pas réussi à y faire face lorsqu'il aurait fallu le faire, ou a abordé la relation de façon dommageable.

2 Le thérapeute a remarqué que la relation thérapeutique représentait un problème, et en a discuté pendant la séance. Toutefois, le thérapeute soit ne semblait pas saisir correctement ce qui se passait dans la relation thérapeutique, soit n'a pas tenté de changer les schémas, les styles d'adaptation, ou les modes qui ont été activés.

4 Le thérapeute a fait un bon travail de constat des problèmes soulevés par la relation thérapeutique. Le thérapeute semblait avoir une bonne compréhension de ce qui se passait entre eux, et réussissait à le communiquer au patient. Le thérapeute a été raisonnablement efficace en utilisant des techniques de schéma pour modifier les réactions inadaptées du patient face à la relation thérapeutique.

6 Le thérapeute a fait un excellent travail de constat des problèmes soulevés par la relation thérapeutique, a compris précisément ce qui se passait entre eux, et a aidé le patient à comprendre les schémas, les modes ou les styles d'adaptation qui ont été activés. Le thérapeute a corrigée les réactions cognitives, émotionnelles, ou comportementales inadapté du patient avec habileté afin d'apporter un changement de schéma dans la relation thérapeutique, en utilisant des techniques appropriées telles que l'auto-divulgation, la restructuration cognitive, la répétition de comportements.

THE THERAPEUTIC RELATIONSHIP IN THE PHASE OF CHANGE

1. limited re-parenting
2. empathic confrontation

LIMITED RE-PARENTING

LIMITED REPARENTING DEFINED

- The therapist tries to meet the core emotional needs not sufficiently met during childhood or adolescence, but also to respect healthy boundaries in the therapeutic relationship

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by A. Hadinia & J. Kossack

FILM: STEP BY STEP LIMITED REPARENTING OFFERING CARE (201)

SCHEMA MODE FLASHCARD

SCHEMA THERAPY ACADEMY
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EXERCISE: LIMITED RE-PARENTING

- Groups of 2
- each person once as a therapist, try limited re-parenting with a client (each person 15min - change after 15min)

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WHY IS LIMITED RE-PARENTING SO IMPORTANT FOR CLIENTS WITH BORDERLINE PERSONALITY DISORDER?

- by addressing the core emotional needs for the BPD client in the therapeutic relationship, one can often help modes, especially the Abandoned Child
- this process helps the client build healthy attachments outside of therapy
- many symptoms of BPD (such as suicidality and self-injury) diminish as the therapeutic relationship with the limited re-parenting grows

SCHEMA THERAPY ACADEMY
by A. Hadinia & J. Kossack

CORE COMPONENTS OF LIMITED REPARENTING

- show warmth, care...
- be an authentic person, not play the role of a therapist; be honest, direct and natural
- empathize with and validate the client's emotions
- "What would a healthy parent want to do for the child?"
- the client can internalize the therapist as the "Healthy Adult" mode
- **ask for positive and negative feedback from the client, what were the client's reactions to you as a person, not just as a therapist**

SCHEMA THERAPY ACADEMY
by A. Hadinia & J. Kossack

EDUCATE THE CLIENT - MORE LIMITED REPARENTING

- Explain the concept of patterns and schemas
- Exploring the client's history during childhood and adolescence also using the YPI
- Building Trust through direct encouragement
- using appropriate self-disclosure, when possible and helpful to the client
- limited re-parenting through imagery

SCHEMA THERAPY ACADEMY
by A. Hadinia & J. Kossack

INDIVIDUALIZE THE RE-PARENTING PROCESS BASED ON NEEDS

- Subjugation → free choice
- emotional deprivation → guidance & protection
- punitivness → forgiveness / self-compassion
- exaggerated personal rights → limits
- abandonment → Stable Base

SCHEMA THERAPY ACADEMY
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FILM: WENDY & JEFF - CAROLINE - MANAGING ANGER IN THE SESSION AND TALKING ABOUT BOUNDARIES

SCHEMA THERAPY ACADEMY
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SET BOUNDARIES WITH THE BULLY & ATTACK MODE

- say "STOP" and use gestures to make your message more visible
- explain the limits
- be specific to explain the limit is what
- be specific about what you need from the client, what needs to change
- if the client does not stop, repeat the limit
- explain the consequences
- be consistent, if the behavior continues, don't be shy to implement consequences

VIDEO DAVID & LUCY
SETTING BOUNDARIES TO A BULLY AND ATTACK MODE

SCHEMA THERAPY ACADEMY
by A. Hadinia & J. Kossack

EXERCISE: SET BOUNDARIES

- 2-person groups
- try to set boundaries with a client who may be too demanding, impulsive or aggressive with you
- 5min each person - change after 5 min
- How did you feel as a client...? and as a therapist...?

SCHEMA THERAPY ACADEMY
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OTHER FORMS OF LIMITED RE-PARENTING

- give a mobile phone number, if possible
- give more time (with limits): phone-calls, emails, texting
- „transitional" objects
- limited holding in severe cases (be careful with that)

RISKS & SAFEGUARDS FOR THE LIMITED RE-PARENTING

- ongoing supervision for therapists to discourage inappropriate behavior and to work with therapists on their own schemas
- limits on self-disclosure
- limits on the manner and frequency of contact outside the therapeutic session
- strict limitations on "holding" (or for how long, depending on the client and therapist, ask permission before doing so!!!)

TRAPS & SCHEMAS OF THE THERAPIST (1)

- giving too much time away from the session - burnout (abnegation)
- feeling inadequate (demanding ideals, failure)
- not setting limits; avoiding confrontation (Subjugation)
- distant, rigid, cold (emotional over-control)
- being angry, resentful (overcompensation)
- discouraging intense emotions & needs (avoidance)

TRAPS & SCHEMAS OF THE THERAPIST (2)

- the client will feel too dependent on the therapist
- too much discussion of non-important topics
- the therapeutic relationship will feel too much like a friendship
- the possibility of romantic feelings in the client or in the therapist
- taking the role of a partner/friend in the client's life, replacing other people, to satisfy the client's needs...

INTENSIVE LIMITED RE-PARENTING

INTENSIVE LIMITED RE-PARENTING BY JEFFRY YOUNG (1)

- Jeffrey Young uses "**intensive limited re-parenting**" with his longer, more difficult and "resistant" clients
- he has made the therapeutic relationship closer the last years with these clients, it is more like a family member (like a parent, older brother, uncle,...)
- by this he has a very close and deep attachment with his clients - he can encourage even more change than before - "Deep emotional healing requires more intense emotional contact" (Jeffrey Young, 2018)
- **healthy boundaries remain active** also with intensive limited re-parenting

INTENSIVE LIMITED RE-PARENTING BY JEFFREY YOUNG (2)

- Jeffrey Young is more vulnerable and uses much more self-disclosure, he is more spontaneous, more open, and shares most of his thoughts & feelings with them
- clients will be free to discuss topics, which are not directly connected with their problems for some of the time (Trump,...), J.Y. explains that this helps to build the relationship and it feels like a "real relationship" for the client
- J.Y. explains that he is even more involved in the daily life of the client, he wants to guide the client with his decisions and gives advice, as part of his protective role for the client

INTENSIVE LIMITED RE-PARENTING BY JEFFREY YOUNG (3)

- J.Y. has more frequent contact with clients
- the sessions are normally longer
- he uses different forms of contact: skype, texting, calls, emojis,...
- the frequency changes with time depending on the problems in the daily life of the client

INTENSIVE LIMITED RE-PARENTING BY JEFFRY YOUNG (4)

- Jeffrey Young describes his sessions with "intensive limited re-parenting" as more spontaneous and less planned
- very open discussion of the therapeutic relationship, including discussion of his role in the client's life
- J.Y. tries to include other family members
- he has found that clients are more likely to come to him during crises and therefore crises are less likely to escalate
- he has much more contact with psychiatrists because of the medication

INTENSIVE LIMITED RE-PARENTING BY JEFFRY YOUNG (5)

- Jeffrey Young describes "intensive limited re-parenting" as a long-term journey together with the client through many life changes
- he feels more free to push clients to make decisions
- he uses even more humor, which makes the sessions more relaxed and sometimes more playful
- he gives more signs of being there for the client, that the client can feel cared for and special (e.g. hugging, emojis with hearts, happy, or sad,...)
- "**Dramatic results with so many patients**" Jeffrey Young, Rome 2018

III. EMPATHIC CONFRONTATION

EMPATHIC CONFRONTATION

- the therapeutic core of schema therapy
- the therapist **empathizes** with the client and confronts the schema/mode
- the aim of the empathic confrontation: **to overcome a maladaptive mode**, which is currently triggered

- empathic confrontation is necessary, because the client is emotionally blocked in this mode
- in this mode the client cannot solve his problems, maybe he can follow the therapeutic process, but in the maladaptive mode the client cannot internalize the issues and it remains very difficult for the client to change
- also the modes of overcompensation sometimes do not respect the limits of the therapist, because of this an empathic confrontation might be necessary

FILM: STEP BY STEP LIMITED REPARENTING - EMPATHIC CONFRONTATION (2.03)

EMPATHIC CONFRONTATION (1)

the therapist expresses his or her understanding

why the client has this schema,

and the difficulty of changing it.

while simultaneously recognizing the need for change

the therapist uses **empathy and confrontation** to evoke change in the client

EMPATHETIC CONFRONTATION (2)

- the therapist uses empathic confrontation whenever the client's schemas or modes are activated in the context of the therapeutic relationship
- the therapist uses self-disclosure in empathic confrontation: he shares his own thoughts/ emotions about the interaction with the client

EMPATHETIC CONFRONTATION- STEP-BY-STEP

1. ***Identify and name the maladaptive mode and behavior regarding***

- in this step the therapist remains clear and determined but also kind / pleasant
- we will name the client's mode and if appropriate we will use self-disclosure of my own feelings

EMPATHETIC CONFRONTATION - STEP-BY-STEP

2. *strengthen the relationship with the client and explain the therapist's intention*

- the therapist stresses, that the client is important to him
- that he does not want to hurt the client with confrontation
- but he wants to help the client reach his goals in therapy
- at this point it might be useful to explain again, that this is only one side of the client and that he has also more pleasant / healthy sides

EMPATHETIC CONFRONTATION - STEP-BY-STEP

3. *Validate the biographic origins of this mode*

- in this step the therapist validates the maladaptive mode in the context of past experiences
- it is really important at this stage to name the reasons in the past why the client developed this mode - it is essential at this point to elaborate the functionality of this mode in the past - "it made sense in the past…"

EMPATHETIC CONFRONTATION - STEP-BY-STEP

4. *Elaborate the pros and cons of this maladaptive mode*

- the therapist tries to elaborate with the client the pros and cons of being in this mode today
- it is important to start with the pros
- we can make a list written on the flipchart, or a paper to take home...
- from micro to macro ...

EMPATHETIC CONFRONTATION - STEP-BY-STEP

5. *Make a decision*

- in this stage the therapist helps the client to make a decision, if he wants to continue using this mode or if he wants to change
- the therapist reassures the client, that he will help and support him during the change work
- but the therapist also wants to affirm the client, that he can also stay with this mode, that it is the client's decision and the therapist will respect it,
- even though the therapist explains, that staying with this mode could bring problems to the treatment

EMPATHETIC CONFRONTATION - STEP-BY-STEP

6. *Change of behavior*

- during the last step the therapist offers alternatives to behave and again reassures the client
- reassures the client once again of his or her support in implementing the new behavior
- perhaps train this behavior in a role-play

FUNNY, BUT NO NO NO...

SCHEMA THERAPY ACADEMY
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EMPATHIC CONFRONTATION STEP-BY-STEP

1. *identifying and **naming the maladaptive mode** and the behavior involved (you need to know, what mode is it???)*
2. *strengthen the relationship with the client and explain the therapist's intention*
3. *validate the biographical origins of this mode*
4. *elaborate the pros and cons of this maladaptive mode*
5. *find a decision*
6. *behavior change*

SCHEMA THERAPY ACADEMY
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EXERCISE: EMPATHETIC CONFRONTATION

- Groups of 2
- each person once as a therapist try empathic confrontation with a client, who is in a mode that blocks the therapy (coping mode like over-compensation, avoiding or compliant surrenderer) - follow the 6 steps of empathic confrontation
- (each person 25min - change after 25min)

FILM: WENDY & JEFF - ADDRESSING THE SELF AGGRANDIZER IN THE THERAPY RELATION

IV. BEHAVIORAL PATTERN-BREAKING

THE PATTERN BREAKING I

- Basic idea: cut the link between the core problem (schemas) and their highly automated dysfunctional strategy at the behavioral level
- Pattern breaking is applied AFTER working on relational, emotional and cognitive changes.
- If the patient already knows these techniques, they can be applied earlier.

THE PATTERN BREAKING II

1. Work on relational, emotional, cognitive change before pattern breaking
2. Identify dysfunctional behavior (case conceptualization)
3. Identify functional behavior
4. Develop a plan for the functional behavior (in small steps!)
5. Practice (role playing, future imagery)
6. therapist gives **homework**
7. therapist uses imagery to overcome avoidance and barriers to change

FUTURE IMAGERY

FOR BEHAVIORAL CHANGE - VIDEO REMCO

_____ 12. APPLICATION OF BEHAVIORAL PATTERN-BREAKING

Therapist applies behavioral pattern-breaking techniques, drawn from schema therapy, in a skillful manner. Behavioral techniques are focused on behavior change, including learning interpersonal skills and limit-setting. Some of the common behavioral pattern-breaking techniques that may be used include:

a. Therapist uses imagery or role playing to rehearse real-life situations outside the session.
b. Therapist and patient discuss new ways of handling life problems outside the session.
c. Therapist discusses how to change dysfunctional patterns in intimate relationships or friendships.
d. Therapist discusses how to change dysfunctional patterns in work or school situations.
e. Therapist pushes patient to make a life change that was discussed previously but was not followed through on, using empathic confrontation or "contingency management."
f. Therapist sets limits when patient "acts out" in a dysfunctional way (e.g., missing sessions, drinking too much, calling therapist at home too much).
g. Therapist discusses making major life changes so patient can get core needs met.
h. Therapist identifies schemas or modes that are blocking patient from making behavioral changes, and uses techniques to overcome obstacles to behavior change.

Exclusion: Rater should not *be judging whether the behavioral technique is a good strategy overall, or whether behavioral techniques were necessary for this session. Therapists should be rated solely on how well they* implement *behavioral techniques in this session.*

Clarification: Role-playing, dialogues, and imagery are generally considered behavioral when they are intended to practice an interpersonal skill, directly change some other behavior, or set limits. If the role-play, dialogue, or image is intended primarily to change emotions *or for limited reparenting, then it is considered an emotion-focused technique. If the focus is on changing thoughts and beliefs, then it is considered a cognitive technique.*

_____ 14. SELF-HELP TECHNIQUES OUTSIDE SESSION

Therapist suggests or assigns appropriate, schema-based "homework" or coping skills that the patient can try during the week *outside* the session, in order to consolidate or advance the therapy work that took place *during* the session. Therapist reviews assignments from the previous session. If patient has not completed previous assignment, therapist explores reasons and attempts to resolve obstacles. Some common self-help assignments from schema therapy include:

- ❑ Flashcard
- ❑ "Transitional object"
- ❑ "Schema Diary"
- ❑ Listen or record audiotape of healthy schema responses
- ❑ Monitor emotions, modes, or schema triggers
- ❑ Mode or schema dialogues
- ❑ Reach out to friends
- ❑ Work on intimate relationships
- ❑ Nurture the Abandoned Child
- ❑ List pros and cons for decision-making, or evidence to test validity of schemas
- ❑ Call therapist when appropriate
- ❑ Practice healthy behavioral changes

N/A Therapist did not assign self-help work, and it was appropriate *not to* assign any for this session. (For this item, "N/A" should only be used for unusual sessions. It is almost always appropriate to assign some kind of self-help work outside the session.)

0 Therapist did not assign or suggest any self-help work outside the session, even though it would have been appropriate and helpful to do so.

2 Therapist suggested or assigned self-help work outside the session, but the assignment was not helpful or relevant to the patient, was much too vague, or was not explained clearly enough for the patient to understand it. Therapist may also have failed to review the previous week's self-help work adequately.

4 Therapist did a good job reviewing previous week's self-help assignment, and working to overcome obstacles if necessary. Therapist assigned "standard" schema-based self-help work to help the patient change schemas and deal with life situations during the coming week. Self-help assignments could have been better-tailored to fit the unique needs of this patient, or to advance the work of this session.

6 Therapist did an excellent job reviewing previous week's self-help assignment, and working to overcome obstacles if necessary. Therapist assigned schema-based self-help work directly relevant to this session, and custom-tailored to help the patient incorporate new perspectives.

TIME FOR REMAINING QUESTIONS...