

schema therapy step by step



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Schema therapy

Schema therapy is an integrative form of psychotherapy developed in the 1990s by Jeffrey Young. In several treatment trials, schema therapy proved to be effective in the treatment of personality disorders and persistent anxiety and mood disorders.

Schema therapy assumes that during their youth every person develops schemas through an interplay of factors such as the temperament of the child, biological and social factors. When there are chronic deficits in validating the basic needs of a child, these schemas are colored by feelings of fear, uncertainty, mistrust, etc. These are called maladaptive schemas in the sense that the extreme overwhelming emotions lead to symptoms and interpersonal problems. Young describes 18 such maladaptive schemas and three kinds of survival strategies and coping styles.

Patients display continued fluctuating moods; the patient can start talking quietly only to be swept up in a sad or angry, self-reproachful mood the next moment. Such moods are called schema modes, modes or 'sides' of the patient; specific schemas and coping styles

dominate one minute while the next other schemas and other coping styles determine the mood.

In the first phase of the treatment, schema therapy focuses on learning to distinguish and recognize such modes. The majority of the treatment is concentrated on re-working those modes so that the patient develops a more realistic self-image and view of the world and is better able to validate his/her basic needs so that the patient feels more secure, more confident or more connected with others. The most important therapeutic instrument used by the schema therapist is the therapy relationship of Limited Re-parenting; the therapist acting as a role model of the good enough parent that the patient should have had as a child. The therapist furthermore uses cognitive, experiential and behavioral techniques and focuses on meaningful experiences in the past, as well as on the present and future.

Introduction

This production follows the whole process of schema therapy from the first to the last session. Although in the course of the curriculum you do learn what the various components of schema therapy are, the application of these components in the different phases of therapy often raises questions.

The purpose of this production is to familiarize novice therapists with all aspects of schema therapy. The treatment of a client with a Borderline Personality Disorder is shown in 91 scenes. All steps of the schema therapy process are shown. It starts by making a case conceptualization, introducing schemas and modes, discussing the results from the questionnaires and using experiential techniques in this phase. Methods and techniques will then be shown in the different phases of the treatment; start phase, therapy phase and end of the therapy.

To teach therapists how to recognize schemas and modes, they are demonstrated in short fragments.

Finally, there are various exercises in which the viewer is invited to consider how he/she would better deal with the session which was shown.

In this booklet, you will find an explanation with useful additional information for each scene shown.

This production can be used as an integral part of a course on schema therapy or as a supplement to training, supervision or intervention.

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Explanation of the scenes

1 Start phase

1.01 > Getting started: exploring patterns and schemas

Limited reparenting is entering into the therapeutic relationship as if you were a sort of parent of the client who is caring and helps her¹ discover how she can best deal with difficult things. That means personal and open contact. That starts at the beginning of therapy; be yourself as much as possible, think aloud so as to offer sanctuary, explicitly state that you will do your best to make the therapy a safe place. A start is made with identifying basic needs. Exploring schemas means alternating between talking about concrete examples and then broadening to general patterns and the use of a downward arrow technique and a diagnostic imagination.

1.02 > Discussing the scores on the YSQ

The feedback of the results from the questionnaires can best be integrated in the conversation about the complaints and experiences. By delving into an experience of the client, the discussion of a schema is more involving. Discussing

1. Where it says 'she', you may also read 'he'. In this instance, we are using 'she' because the client in the recordings is a woman.

the schemas must encompass more than just stating the names of the schemas; these names represent a deeply felt experience. Describing that experience helps the client to recognize her relevant schemas and to experience that the therapist understands her.

1.03 > Diagnostic Imagery

Do not wait too long to introduce a first diagnostic imagery exercise. An imagery exercise can be done in the first or second session (latest). This first phase is only aimed at exploration of the schemas and modes. The imagery exercise is thus still without rescripting. There are two ways to introduce the exercise; it can simply be announced as an exercise or a link can be made to what the client is telling us. In the latter case, the imagery exercise is a tool to better understand why the client is so affected. The explanation regarding the method should not be too long; it is better to generate an experience and afterwards cognitively discuss what has happened. However, it is helpful for the client to inform her about the duration of the exercise and to emphasize that the client retains control at all times. First creating a safe place is not strictly necessary but it is an easy way to get

the imagination going. The emotional bridge should describe the emotional, cognitive and physiological aspects in order to generate underlying, meaningful memories as best as possible.

1.04 > Introducing modes

There are different ways in which modes can be introduced. A natural way is to connect the modes to the perception of the client. Discussing the repression of feelings, in contrast to overwhelming feelings at other times, can lead to a discussion of two different sides of the client. You can then search for names for those sides that fit the client's perception. Do not just name the different sides but support that with gestures as if you are pointing to different people.

1.05 > Discussing the mode model

You share the mode model with the client and together you can build on it in the session. The aim is to visualize the different modes, generating more insight and overview, also by typifying the experience per mode. By varying the size of the modes, you can better match the experience of the client. One client, for example, has a very strong, and thus significant, protector, the other a very strong and significant Punitive Parent.

1.06 > Discussing goals of therapy

Be clear about the objectives in the therapy. That is: negotiating with the

Protector, fighting against the Punitive Parent and providing for the needs of the Vulnerable Child and the Angry Child in order to strengthen the Healthy Adult side of the client. It helps to present this message clearly, in simple terms.

The client does not yet have a Healthy Adult side that is able to understand a complex explanation. Here again, the question 'How would I explain this to a child who feels sad and anxious?' can be helpful. At this initial stage of the therapy, only limited agreements are made about the therapy conditions on the basis of the same assumption that the Healthy Adult side of the client is not strong enough to make this type of agreement.

1.07 > Mode guessing game

One of the most important goals in the initial phase of therapy is that the client learns to recognize the modes and increasingly learns to think in terms of modes. The 'guess-the-mode' game is a somewhat lighter way to achieve this goal. The nice thing about this method is that more attention can be paid to the non-verbal signals of the modes. The question of whether the client wants to engage in the modes herself invites the client to immerse herself in the modes and for that she needs to become more aware of all the different characteristics of the modes.

2 Treatment Phase

2.01 > Limited Reparenting - Offering care

In the first place, good care means connecting with the client's experience. To this end, it helps to keep the image of the client as a small child in mind. On an emotional level, the client is overwhelmed by old pain from her childhood. The leading question for the therapist can then be: "What would I do/say if this were really an upset child?". The answer is not to come up with solutions immediately but to first acknowledge what the client feels and, where possible, make a connection with her experiences from the past that exacerbate the emotions. Care often means a soft, warm tone of voice, a slow pace and reassurance, rather than suggesting well-meaning solutions. State that it is good that the client now dares to talk about it and ascertain whether she has thought about the crisis plan.

2.02 > Limited Reparenting - Providing direction

Limited Reparenting means, among other things, that you, as a therapist, interfere in a personal and active manner with the important life choices of the client. The only emotion-regulating mechanisms that clients have are the coping styles of overcompensation,

avoidance or surrender. In these behavioral reactions, scant attention is paid to what is felt, what the underlying needs are and what the exact problem is. The switch 'to action' is immediate. Giving direction often means slowing down and sympathizing and in the meantime actively thinking about what could change in the important areas of life in the longer term.

2.03 > Limited Reparenting - Empathic Confrontation

Limited reparenting does not only mean caring and directing, it also means confronting in an empathic manner behavioral patterns that are not helpful and that prevent the basic needs of the client from being fulfilled. An empathic confrontation can be conducted in different ways, but within Limited Reparenting it means at least confronting in a personal way.

The following step-by-step plan can help to shape the empathic confrontation:

- 1 the therapist examines for him-/herself which behaviors interfere in communication.
- 2 the therapist confronts the client in a friendly but clear way.
- 3 do this in small steps and contemplate the emotions this calls up.
- 4 expand this example to a broader pattern of behavior.
- 5 make a connection with the historical

background and the modes that have developed as a result.

- 6 appoint a healthier alternative that is more in line with the needs of the client.

2.04 > Limited Reparenting - Limit setting

Drawing a limit also implies that there are consequences if that boundary is not respected. These natural consequences are announced in advance. The next time the problem behavior occurs, it is again explained why the boundary is there and the consequence is put into effect. If necessary, these consequences increase in severity up to the point that the therapy is interrupted or stopped altogether.

2.05 > Detached Protector - Chairwork

The therapist uses chairwork to explain the protective function of the detached protector. The therapist then tries to bypass the Detached Protector and connect to the Vulnerable Child. The therapist identifies the Detached Protector in the session. The therapist asks the patient to move to another chair and explain, as the Detached Protector, how this coping mode is helpful for the patient. The therapist points out that the Detached Protector is not solving anything and offers a different, more healthy approach. The therapist then asks the patient to

move back to the original chair next to him and tries to connect to the Vulnerable Child, reassuring and comforting her.

If necessary the therapist asks the patient to go back for a short while to the chair of the Detached Protector to hear new arguments. Finally, the therapist asks her to return to the chair next to him to connect to the Vulnerable Child again.

2.06 > Historical role play

The historical role play consists of several phases:

- 1 identification of behavioral patterns, schemas in which the client gets stuck and preliminary discussion about a meaningful past situation that underlies the schemas.
- 2 reenactment of this historical situation in which the client plays herself (as a child) and the therapist the other (father).
- 3 discussion of the role play and identification of the learned assumptions about herself and/or the other.
- 4 reenactment of the historical situation in which the client plays the other (father) and the therapist plays the client as a child. The therapist clearly indicates the father's circumstances at the time, so that the client can play the father of that time as best as possible.

- 5 Discussion of the role play. The therapist first asks the client questions in the role of father and checks whether the father really thinks what the client initially concluded. Then test the credibility of the assumptions again. Then discuss how the client would want to respond in the historical situation, but with today's knowledge. Emphasize that the desired behavior in the past was not yet possible, but that she can try it out now.
- 6 reenactment of the historical situation in which the therapist plays the other (father) and the client stands up for her needs.
- 7 discuss this experience and give a lot of affirmation for what the client has tried. Together formulate the other perspective (father cannot be reasoned with) and an alternative conclusion about herself (I can give my opinion). This builds healthy schemas.

2.07 > Bully & Attack-Empathic confrontation

The therapist uses the same steps when doing an empathic confrontation. The Bully & Attack mode, like any other form of overcompensating coping mode, has an escalating effect, easily triggering the therapist to start to talk faster or to argue. The therapist has to de-escalate by looking away from time to time, giving small summaries with

explicit understanding of the patient's feelings, trying to keep a calm tone of voice.

2.08 > Punitive Parent - Imagery rescripting

With rescripting, there are different variations in the use of imagination. For example, the therapist can first start with a safe place or directly engage with the upsetting feeling that the client already has or directly evoke a picture of a recent situation that caused a bad feeling or directly go to a meaningful image from the past.

In the most comprehensive variant, the steps are:

- 1 explanation of aim and method
- 2 safe place
- 3 recent trigger situation
- 4 emotional bridge to the past
- 5 visualization of the original meaningful event
- 6 rewrite that event
- 7 back to the safe place
- 8 post-discussion.

2.09 > Bullying Peers - Imagery rescripting

Sometimes the antagonists in the historical situation are not a parent but peers. In these situations, the therapist must decide if he addresses the bullying children, and/or the teacher who might be involved in the situation.

2.10 > Punitive Parent - Chairwork

Sending away a Punitive Parent mode using the multi-chair technique has several steps:

- 1 Identifying and naming the Punitive Parent mode.
- 2 Place the client in another chair and ask her, from this punitive experience, to indicate what is wrong with the client. Let her say it to little Sandra (empty chair).
- 3 Interrupt these punishing messages after a few sentences and ask the client to sit next to you. Indicate that the punishing side stays behind on that other chair.
- 4 Explore the emotions of the Vulnerable Child and, if possible, identify the historical roots of the Punitive Parent.
- 5 The therapist addresses the Punitive Parent with the strength necessary to win.
- 6 Regularly check the client's feelings and after a few attempts to silence the Punisher, put the Punisher's chair out of the door if necessary.
- 7 Comfort the Vulnerable Child.
- 8 Round off with a cognitive framework in which the Healthy Adult will understand more about what happened.

2.11 > Punitive Parent - Cognitive technique

When challenging the (messages of) the Punitive Parent, it is also important

to submit arguments that show that the Punitive Parent is not right. Cognitive techniques offer an opportunity to explicitly highlight these arguments, such as a more dimensional evaluation in this scene. There are several variations on this technique and for a description of this reference is made to literature from cognitive behavioral therapy.

2.12 > Vulnerable Child - Circle Diary Form

Clients have a tendency to have extreme reactions at an emotional, but also at a cognitive level, under the influence of their modes and schemes. They draw conclusions that are incorrect or premature, without examining what alternative explanations there might be for a difficult situation. In this fragment, together with the client, we go over her first automatic reactions and thoughts after a friend cancelled an appointment by making a cognitive circle. We look at the influence of the dysfunctional thoughts on her feelings and behavior and what the real need was. This creates a more nuanced view of the whole situation.

2.13 > Vulnerable Child - Audio flashcard

Recording an audio flashcard as a therapist has several advantages. On the one hand, it provides a tool for the client to remember and further internalize the factual arguments

against parent mode. On the other hand, a recording with the voice of the therapist who says nice things is also a transitional object, which helps to further internalize the therapist.

2.14 > Vulnerable Child – Set homework

The therapist gives homework assignments at the end of every session, right from the start of therapy. In the first phase of therapy, the therapist suggests homework that is aimed at a better understanding of modes and that the therapist, and the therapist's messages and the use of an audiotape and diary forms are helpful in achieving this.

2.15 > Angry Child – Ventilate, Empathize, Reality testing

In the Angry Child mode, not only is the anger felt about the current trigger situation but also the pent-up anger about all the injustice which the client has experienced in the past. If the client has never been given the opportunity to express this anger, then ventilating all anger in the session is very healthy as it validates the suppressed need for self-expression. Note that this strategy works in child modes and not in coping modes. Furthermore, the strategy of ventilating-empathizing-reality testing should be adapted if other basic needs than self-expression are relevant to your client.

2.16 > Angry Child – Chairwork

At the start of the therapy, the emphasis in handling the Angry Child is to vent all the old anger. In the later stages of therapy, the Healthy Adult should learn to express the anger in a different way so that the connection with others is not harmed. The therapist coaches the Healthy Adult in expressing anger in a controlled manner.

2.17 > Structure of complete session with transitions via black

Listen carefully at the beginning of the session as to which mode is active. That can be heard, among other things, by the tone of voice and the way in which the client talks about herself. Choose a strategy that suits that particular mode: in coping mode you want to circumvent, in parent mode you want to challenge, the Angry Child should get a chance to vent all anger and the Vulnerable Child should be validated in her basic needs. In one session, multiple techniques can be applied depending on the process in the session. At the end of the session, time should be allowed to cognitively anchor all experiences and the therapist will address the Healthy Adult more explicitly. Homework is given at the end of each session.

3 End of Therapy

3.01 > Empathic Confrontation

In the final phase of therapy, the empathic confrontation may be somewhat clearer than at the beginning. The therapeutic relationship is strong enough for this and the client can appeal more to her Healthy Adult. The therapist speaks more clearly to the Healthy Adult, names the modes he hears and tries to let her Healthy Adult take control. Addressing the Healthy Adult is accompanied by a different tone of voice than in the beginning of therapy and the therapist will address the Healthy Adult more explicitly about her responsibilities.

3.02 > Detached Protector – Chairwork: coaching the Healthy Adult

In the final phase of therapy the therapist coaches the Healthy Adult mode of the patient in bypassing her coping mode. The therapist identifies that the coping mode is present in the session and asks the patient to sit in another chair. The patient explains the pro's of the coping mode. The therapist then asks the patient to move to the original chair beside him and asks the patient to argue using the coping mode from a Healthy Adult point of view. If necessary, he asks the patient to move back to the chair of the coping mode.

Finally, the patient concludes from the Healthy Adult mode that she wants the coping mode to take a step back more often in the future.

3.03 > Detached Protector – Chairwork: therapist plays coping mode

Strengthening the Healthy Adult at the final phase of therapy requires the patient to argue with her coping mode herself. The therapist plays the coping mode, at the same time supporting and coaching the patient in expressing healthy arguments.

The therapist introduces the exercise as a way of strengthening the Healthy Adult side.

The therapist takes a place in the chair of the coping mode and starts explaining why this side is helpful.

The patient has to oppose this coping mode with specific arguments. If needed, the therapist supports the patient in the role of the Healthy Adult. The therapist goes on until the patient has refuted all the arguments of the coping mode.

3.04 > Punitive Parent – Chairwork

At the end of the therapy the role of the therapist is more coaching than directing; the Healthy Adult side of the client must now learn to fight the Punitive Parent. The therapist's coaching may entail that words are still proffered, encouragement given to repeat certain

statements or to repeat them more forcefully. Saying these arguments against the punisher out loud also makes these arguments more believable.

3.05 > Punitive Parent - Imagery Rescripting

Imagery with Rescripting. In the final phase of therapy, the therapist uses the Healthy Adult in rescripting. This is done in three steps:

- 1 First, the client makes contact with the original situation, in which she is the child (little Sandra) who experiences the unpleasant situation.
- 2 The scene then reverts to the beginning, but the client assumes the role of her Healthy Adult (Big Sandra) and she intervenes until it is safe for little Sandra. Finally, she comforts little Sandra.
- 3 Again, the scene reverts to the beginning and now the client is again little Sandra, who experiences what Sandra does to protect and comfort her. This scene starts with the first step. It can be helpful to start the imagination exercise by visualizing the Healthy Adult so that this mode is already somewhat activated. This makes it easier to visualize that Healthy Adult in step 2.

3.06 > Healthy Adult - Identifying the Healthy Adult

Throughout the entire therapy, work is

being done to strengthen the Healthy Adult. Initially this is primarily through experiential techniques and psycho-education. In the final phase of the therapy, what the client can do to make contact with her Healthy Adult is discussed more explicitly. One of the possibilities is that when confronted with a difficult situation, the client will think back to an image in which she soundly resolved something through her Healthy Adult. During the visualization of the Healthy Adult, attention is paid to the various attributes of this mode such as the physical posture, cognitions, emotions and physiological aspects that belong to the Healthy Adult. Finally, it is discussed how this side differs from the dysfunctional modes.

3.07 > Healthy Adult - Psycho-education

The therapist gives psycho-education about a healthy adult way in coping with difficult situations in three steps:

- 1 Pay attention to your emotions and be kind and accept what you feel.
- 2 Be aware of coping and or parent modes that try to interfere.
- 3 Reality testing: What do you need, and what action validates these needs?

3.08 > Future Imagery - Mode awareness & mode management

This imagery exercise in this final phase of therapy is focused on strengthening the healthy adult and becoming aware

of the dysfunctional modes that can interfere. The patient learns how to reconnect to her Healthy Adult, when the other modes try to take over.

3.09 > Future Imagery - Behavioral change

The final phase of therapy increasingly focuses on the necessary behavioral changes and the client must prepare for possible trigger situations in the future. Imagination exercises in this phase of therapy are now mainly used to visualize the Healthy Adult handling these challenging situations.

- 1 Pre-discussion of old modes and the desired behavior in trigger situations.
- 2 Visualization of a likely trigger situation and feeling the old reactions.
- 3 Making contact with the Healthy Adult and visualizing the desired response.
- 4 Repetition of this Healthy Adult helps to better internalize this.

3.10 > Healthy Adult - Dealing with conflict

Different modes were activated upon confrontation with a challenging and triggering situation. The therapist is not pointing out the modes anymore but pushes the Healthy Adult to identify these modes herself. He then pushes her to comfort little Sandra and practice the three steps of the Healthy Adult.

3.11 > Homework assignments

When the patient has learned to manage conflict situations from the Healthy Adult side, the therapist gives her homework to rehearse managing these conflicts in this way, whenever they occur again. He also points out that it is possible that she will not always succeed. Consequently, her other homework is that she has to fill in a diary form about a situation that didn't go well.

After three weeks, the patient discusses the way she handled two conflict situations.

The therapist compliments her for the things that went well. They also discuss the fact that she didn't fill out the diary form after a conflict that got out of hand. In this phase of therapy, the therapist presses the importance of homework assignments.

4 > Examples of schemas

For a detailed description of schemas, see 'Schema-focused therapy, handbook for therapists' by Young, J.E. Klosko, J.S. & Weishaar, M.E. (2005)

5 > Examples of modes

For a detailed description of modes, see 'Schema therapy - a practical guide' by Arntz, A. & Jacob, G. (2012)

Answers to the exercises

6.01 > Exploring patterns & schemas

The therapist's tone is more mature, more business-like and speaks in terms of modes, appealing to the Healthy Adult who may or may not be there or who is barely there. There is less help with naming problems and feelings. The therapist's writing is not bad in itself, but in combination with the tone and tempo, the contact remains somewhat cognitive and therefore too distant. The switch to coming up with solutions instead of gaining insight into patterns takes place too quickly. The relationship between the complaint situation is discussed as a hypothesis without first being explored.

6.02 > Identifying different schemas - 1

Abandonment - Dependence - Failure - Shame/Defectiveness - Enmeshment - Subjugation - Self-sacrifice

6.03 > Identifying different schemas - 2

Emotional Deprivation - Social Rejection - Vulnerability to illness/harm - Social Isolation/Alienation - Entitlement - Lack of self-control/discipline - Emotional Inhibition

6.04 > Identifying different modes - 1

Punitive Parent mode - Angry Child mode - Angry Protector

6.05 > Identifying different modes - 2

Healthy Adult mode - Detached Protector - Vulnerable Child mode

6.06 > Discussing the scores on the YSQ

The therapist shows all results in one go, making this a somewhat overwhelming experience for the client. Discussion of the diagrams is often done using the formal description of the diagrams as they are described in the literature, without making them more consistent with the client's experience. The pace is fast and makes it even more rational and the therapist does not seem to connect well with the client. Finally, the therapist seems to find the outcome quite serious, which will increase the feeling of failure in the client. Just saying that it will all work out is not enough then.

6.07 > Diagnostic Imagery

Too much information is given in advance about the exercise through which the anticipation anxiety is increased. The tempo is too fast and the tone of the therapist's voice is too businesslike, making it difficult for the client to actually feel emotional experiences. It is relayed in the past tense making it more of a description of the image rather than an experience.

Too much time is spent on a traumatic memory, so it is experienced again. The transitions from the different phases of the exercise go too fast and the debriefing is too cognitive. There is no connection with the client's experience and little or no emotional reflections are given.

6.08 > Offering care exercise at start of therapy

The therapist addresses the client too much as a Healthy Adult while the client is in a Vulnerable Child mode. The therapist should realize that he is dealing with a sad child on an emotional level. That means that the tone of voice should be less mature and rational. In terms of content, the therapist may be somewhat more focused on the emotional experience instead of the behavioral change that he strives for. The pace should be slower and more emotional reflections could be given as well as more explicit recognition of the client's feelings.

6.09 > Providing direction at the start of therapy

The therapist approaches the client too quickly and too often as a Healthy Adult at this stage. With a Healthy Adult it is very good to give that person the space to make his/her own choices. However, such freedom is too unsafe and threatening for a child. In addition,

the therapist only discusses the practical aspects of the choice and does not address the concerns, the fears, the basic needs and the effects of overly abrupt choices.

6.10 > Empathic Confrontation - 1

The therapist says sensible things but the pace is too fast. The speaking rate is too fast and too many steps are taken whereby the connection with the client is lost. This leads to more of a discussion or conflict occurring than that the client acquires more insight into herself.

6.11 > Empathic Confrontation - 2

The therapist is too hesitant in this scene and there seems to be over-emphasis on the empathic part of the technique. The uncertainty that is shown makes the situation unsafe for the client.

6.12 > Limit setting - 1

The boundary is set in a somewhat abstract way; it is the institution's rule that there is no drinking before the session, but apparently not the therapist's. The therapist only discusses the effect of alcohol and how that hinders the therapy. He does not say this in a personal way. The consequence is stated and immediately carried out rather than implementing it at a subsequent infringement.

6.13 > Limit setting - 2

The therapist is too hesitant, seems unsure in setting limits and speaks to the client too much as a Healthy Adult who can decide for himself what is healthy or not.

6.14 > Schema interactions

Client did not do homework > Therapist responds, setting ruthless standards > Failure and disappointment are activated in the client > The therapist is a bit surprised about this, and then self-sacrifice is activated in her.

6.15 > Mode interactions

The therapist suggests an imagination exercise > Client refuses this from an angry overcompensating coping mode (Angry Protector or Bully & Attack?) > Therapist responds from her Compliant Surrender > Client seems to respond from an Angry Child mode in which the vulnerability can be heard > Therapist seems to react from her Control-keeping protector, which makes her appear critical > Client now switches to Vulnerable Child mode > Therapist now seems to be focused on the needs of the client, which can come from a coping mode or Healthy Adult.

6.16 > Chairwork: fighting the punitive antagonist - 1

The therapist allows the Punitive Parent mode to continue for too long

without interrupting it. Then he talks about challenging the punishing messages but does not do it directly. There is no conviction in the therapist's voice; the proposal of a chair technique sounds hesitant.

6.17 > Chairwork: fighting the punitive antagonist - 2

The transitions are too fast, the therapist is also looking at the client when he acts angrily to the parent mode. Sending the parent away, by putting the chair away, takes place very quickly, so that the effect remains superficial.

6.18 > Dealing with anger - 1

The therapist's schema of subjugation and self-sacrifice seem to be triggered and he is primarily focused on the feelings and needs of the patient without paying attention to his own needs or thoughts about what happened.

6.19 > Dealing with anger - 2

The therapist's schema of failure is triggered and he seems to be surrendering to a feeling of being responsible for messing up things for the patient.

6.20 > Dealing with anger - 3

In this situation, the therapist's schema of unrelenting standards is being triggered, causing him to argue with the patient about the specifics expressed in her anger.

Therapists

Remco van der Wijngaart

Remco is a psychotherapist and supervisor/trainer of cognitive behavioral therapy and schema therapy.



From 1997 to 2016 he worked as a therapist at an outpatient institution in mental health care for anxiety, eating, somatoform and personality disorders. During this period Remco was involved in the scientific research of Maastricht University in the area of treatment of these disorders. He was trained in schema therapy by Jeffrey Young. Remco currently works as a cognitive behavioral therapist and schema therapist in an independent practice in Maastricht. He has been Vice-President of the International Society of Schema Therapy (ISST) 2016-2018.

In addition to clinical work, since 1996 Remco has been teaching various components of cognitive behavioral therapy and schema therapy, both at home and abroad. Since 2010 he has produced several DVDs in the field of Schema therapy and Cognitive behavioral therapy.

2010 > Schema Therapy, Working with Modes

(In collaboration with David Bernstein)

2016 > Fine Tuning Imagery Rescripting

(In collaboration with Chris Hayes)

2016 > Schema therapy for the Avoidant, Dependent and Obsessive-Compulsive Personality Disorder

(In collaboration with Guido Sijbers).

2018 > Fine Tuning Chairwork in schema therapy

(In collaboration with Chris Hayes)

Marjon Nadort

Marjon Nadort is a Mental Healthcare Psychologist and Psychotherapist. She is a Supervisor of Cognitive Behavioral Therapy, and a Certified Supervisor and Trainer in Schema Therapy (ISST).



Marjon was trained and supervised in Schema Therapy personally by Dr. Jeffrey Young from 1996 until 2000. In 2012, Marjon was awarded her PhD for her thesis "Wild at heart and weird on top: the implementation of outpatient schema therapy for borderline personality disorder in general mental healthcare." She works as a psychotherapist and trainer in private practice in Amsterdam, the Netherlands.

Since 2000, Marjon has been presenting and providing training courses in Schema Therapy worldwide on Borderline Personality Disorder,

including recent trainings on Narcissistic Personality Disorder (NPD) in Indonesia and Australia. She produced and directed the DVD series 'Schema Therapy for Borderline Personality Disorder' in 2006, which was one of the first instruments to help teach schema therapy in the Netherlands.

Together with Michiel van Vreeswijk and Jenny Broersen, Marjon edited The Handbook of Schema Therapy (Wiley Blackwell, 2012). She is a co-author and editor of several schema therapy chapters and articles.

Susan Simpson

Dr. Susan Simpson is a Clinical Psychologist who, for the past 20 years, has specialized in therapy for complex trauma and eating disorders. She currently runs a Schema Therapy training program in Scotland and works part-time in an inpatient eating disorders unit.



She is part of an international research group which is researching the effectiveness of Schema Therapy for eating disorders. Her research includes studies on the role of schema modes in the development of pathology, and the effectiveness of group Schema Therapy for eating disorders. She has published several research papers on the schema therapy model applied to a range of clinical populations and has presented her findings at national and international conferences. For a list of research publications, see: www.researchgate.net/profile/Susan_Simpson/contributions

Hannie van Genderen co-producer

Hannie is a clinical psychologist and supervisor and trainer of cognitive behavioral therapy and schema therapy. She works as a clinical psychologist at the Virenze Riagg in Maastricht. She gave courses and developed curricula



for psychotherapy, cognitive behavior therapy and schema therapy at the RINO Zuid-Nederland from 1980-2010. In addition, she has been the owner of 'Van Genderen Opleidingen' since 2000 (see www.geschamatherapieopleidingen.nl). She provides a range of courses on schema therapy at home and abroad.

Since 1987 Hannie has been involved in scientific research at Maastricht University in the area of treatment of a wide range of mental disorders.

From the very beginning in 1996 she has been involved in the introduction of schema therapy for personality disorders in the Netherlands. She was trained by J. Young, A. Beck and C. Padesky. The Schema-focused Group Therapy program of Farrell & Shaw was added in 2006.

Hannie is co-founder and board member of the Schema Therapy Register (2006-2012) and was on the board of the International Society of Schema Therapy (ISST) from 2012 to 2015.

She has written chapters on schema therapy in various Dutch textbooks and is, together with Prof. A. Arntz, is author of the book Schema Therapy in Borderline Personality Disorder (2010). 'Patronen doorbreken. Negatieve gevoelens en gewoonten herkennen en veranderen' [Breaking through patterns. Identifying and changing negative feelings and habits] a (self-help) book for people interested in schema therapy was published in 2012.

Actress

Client 'Sandra'

Jet Pagnier (actress: Amsterdam)

The client is a 25-year-old woman who presented with anxiety, escalating quarrels with her boyfriend, self-harm, mood swings and depressive episodes. She lives independently, has a social network with 1 meaningful friend, Linda.

She has a relationship with a young man who has no regular work and regularly uses drugs and alcohol. Sandra cleans people's homes, working 24 hours/week.

She has a very low self-image with doubts about her abilities. As a result of this insecurity, she can lose herself in an avoidance of social activities which makes her feel lonely and depressed, or she tries to keep herself on balance by being tougher than she feels with the result that she feels exhausted and overwhelmed.

Diagnostically, there is a recurrent depressive disorder in partial remission, a generalized social phobia.

Furthermore, there is a Borderline Personality Disorder with Paranoid, Dependent and Evasive features. Father is described as a dominant, aggressive man who was inclined to

drink out of insecurity. Without alcohol, the father was verbally aggressive but with alcohol he escalated to throwing things. He also hit Sandra a couple of times but usually the aggression was aimed at her brother.

Mother is a gentle, kind but also anxious and adaptive woman. For fear of her husband, mother often kept her mouth shut and did not protect the children. After the father's outbursts, she tried to soothe things over and get back to normal as quickly as possible. Her statements were 'Ah, you know how he is' and 'You had better stay quiet, saying something will only make things worse'.

Sandra has always felt lonely and different in relation to peers. Her family was considered to be different and people were a bit afraid of her father, which made it more difficult for Sandra to connect with her peers.

She did well at school; she has average to above-average intelligence, but due to her own insecurity and the problems at home she just managed to complete lower-level vocational secondary education (VMBO).

After several complaint-oriented treatments, Sandra was now indicated for treatment focused on her Borderline Personality Disorder.



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